Lincolnshire COUNTY COUNCIL Working for a better future

By email
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HM Coroner for Lincolnshire
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Head of Safeguarding
Adult Care & Community Wellbeing
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20 June 2023

Dear Mr Cooper

REGULATION 28 REPORT – COLIN ROBERT GUMM

Thank you for your letter dated 27th April 2023 enclosing your Regulation 28 Report following the inquest investigating the death of the late COLIN ROBERT GUMM. As required under Section 7 of your report, we have now considered your points and respond accordingly.

Conclusion of the Inquest

"The deceased (who was a vulnerable adult upon a care package) died on 27th November 2021 at Lincoln County Hospital, Greetwell Road Lincoln where he was admitted having been found in a collapsed state by his carers that day. Sadly despite treatment his condition deteriorated and he passed away the same day. A safeguarding referral was subsequently made."

Your concerns

Your concerns listed in the report are:

1. **Adult Social Care were first involved in 2017 due to the deceased self-neglecting. It is recorded assessments were not able to be completed.**

The coroner had evidence within the safeguarding statement that the recorded assessments were not able to be completed due to the individual's lack of engagement with the authority. Where an individual has capacity to refuse to engage with a service, they are entitled to do so. LCC are not able to force an individual to accept services or an assessment.

2. **It was not until April 2021, 3 years later and despite care packages being in place and funded by Lincolnshire County Council, that the deceased became known again to Adult Social Care where it was deemed necessary to provide ongoing support of the Wellbeing Team and Adult Social Care**

until his passing in November 2021. This was as a result of a referral from the GP.

3. **What happened in those 3 years by way of observations upon the deceased by safeguarding and if none shouldn't there have been something in place? Nothing has been evidenced to date. Shouldn't measures have been in place to review/or monitor?**

This factual basis is incorrect. There were no packages of care provided or funded by Lincolnshire County Council ('LCC') between 2017 and April 2021. Furthermore, there was never any doubt about Mr Gumm's capacity to make his own decisions about his own care and support and in fact he made his own private arrangements. As LCC were not involved in the commissioning of any care for him, LCC would only become involved if a safeguarding concern was raised or if he had changed his mind about wanting support and was eligible for that support. Aside from the referral already referred to in the safeguarding statement, there were no safeguarding referrals which came to the attention of LCC in those 3 years. So, in summary there would not have been, nor should there have been, observations of him by safeguarding nor reviews of his care as this was not the responsibility of LCC.

He did however have significant health issues so he will have been in touch with health services to support his health care.

On 14.4.21 a concern was raised by a Census volunteer (gathering information for the national census) that they had visited Mr Gumm several times and could not get a response. As a result, police carried out a welfare check and confirmed his safety. As Mr Gumm could not be contacted by telephone due to his telephone line being disconnected, a duty officer arranged to visit. At the home visit, Mr Gumm declined an assessment, but the worker gave him advice and information and a referral was made to the Wellbeing Service for a benefits check and for assistance with shopping, cleaning and a key safe. A referral was also made to Age UK. Some information was provided verbally, and some information was posted. It was noted that he had terminal blood cancer. The Wellbeing service at LCC supported with information about cleaning and shopping services; applying for an Attendance allowance; and telecare equipment. Wellbeing also identified that he would benefit from a stair rail. Wellbeing was to complete a follow up call but due to disengagement contact was closed on 27/4/21. There was no concern about Mr Gumm's capacity, and he was therefore entitled to refuse an assessment and/or services. He was also noted to be a self-funder. A self-funder is someone who has resources over the capital threshold limit and who is not entitled to state support.

There were further examples of Mr Gumm making an active choice to refuse assessments and or services. Some of these and other related information are documented below: -

- 12/5/21 a needs assessment was started by ASC and wellbeing hub but was not completed as Mr Gumm had said that he wishes to attend hospital appointment before deciding if he would like support.

- 27/05/21 Mr Gumm declined a falls assessment.

- 28/05/21 As a result of Covid arrangements Mr Gumm was provided with 2 weeks of funded care by health. After that arrangement Mr Gumm declined to have care either private or brokered through LCC. It is recorded that there were no concerns about Mr Gumm's mental capacity to decline care and he had insight into his needs.

- 01/06/21 Mr Gumm was taken to A&E following a fall. He consented to ASC contacting agencies on his behalf to arrange a **private care package.** The private care package was identified but postponed due to admission to hospital for treatment.

- 12/06/21 Mr Gumm was discharged home with **private care** via Amber Care.

- 06/07/21 ASC received a Lincolnshire Fire and rescue notification. Mr Gumm accepted the installation of x3 smoke detectors and a CO2 detector.

- 07/07/21 Home visit was undertaken by wellbeing and identified rails for around the property.

- 09/07/21 – A review was completed by hospital social work team with Mr Gumm who said "Amber care are fantastic". He **declined to have a needs assessment** but said maybe a call from area team in the future. It was highlighted that the boiler was not working. A neighbour offered to contact the engineer for Mr Gumm. A Wellbeing referral made by fire service for a financial review re benefits.

- 02/08/21 Mr Gumm was admitted to hospital 20/07/21 following a fall and fracturing right femur.

- On discharge Mr Gumm decided to go to a care home. He was **self-funding** his care as above the financial threshold. A placement was found at The Laurels care home which Mr Gumm agreed to.

- 10/08/21 Mr Gumm was discharged to The Laurels, which he was self-funding.

- 23/08/21 hospital social work team called and spoke to Mr Gumm **who declined an assessment.**

- 27/08/21 The OT at the GP surgery made a new contact to ASC. Mr Gumm was stating he wished to return home and was needing some support.

- 13/09/21 The OT arranged equipment. A **Needs assessment was offered, Mr Gumm declined but asked for support to be arranged privately.**

- 14/09/21 – Agencies were contacted, and Bluebird Care had capacity. Mr Gumm agreed to them visiting him to see if they could meet his needs.

- 16/09/22 The Laurels was due to close. A needs assessment was completed by agreement in order that Mr Gumm could move elsewhere. A placement was

found for him at Homer Lodge in Lincoln. Once again this was a **self-funded** placement.

- 22/09/21 A Needs assessment and moving and handling plan were emailed to Bluebird Care for their information. Confirmation was received from Bluebird Care that they could meet needs.
  ASC spoke to Mr Gumm over the phone, and he said Bluebird Care visited the day before and could meet his needs but were unable to start for 2 weeks.

- 24/09/21 Confirmation form Bluebird care could start on 05/10/21.

Mr Gumm did not receive any commissioned care from LCC. He refused most attempts to assess him, and he refused services deciding (with capacity) to commission his own care arrangements.

3. **EMAS make their own safeguarding referral on 29th November 2021 as he appeared to them on the one time, they saw the deceased that he was underweight and showing signs of clinical dehydration. If they were able to observe this why is no one else in Adult social care making the same assessment during his lifetime.**

Adult social care was not involved in the provision of Mr Gumm's care and therefore had no opportunity to be sighted on it unless a referral of a safeguarding nature was made. No such referral was made. Bluebird Care was the agency providing his privately arranged care.

4. **After his death LCC decide to undertake a s.42 assessment under the categories of neglect and acts of omission.**

5. **The outcome from the "limited information gathered" was that no risk was identified and no action taken. Despite the toxicology report still to be received the enquiry was closed and never reopened. As a result no appropriate action was taken to mitigate any risk to others.**

The evidence before the coroner confirmed that the safeguarding referral was reviewed by the Adult Safeguarding Team to establish whether the criteria for a Safeguarding enquiry under Section 42 of the Care Act 2014 ("s.42") was met. S.42 of the Care Act is detailed below.

Enquiry by local authority

(1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—

(a)has needs for care and support (whether or not the authority is meeting any of those needs),

(b)is experiencing, or is at risk of, abuse or neglect, and

(c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

(2) The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

(3) "Abuse" includes financial abuse; and for that purpose "financial abuse" includes—

(a)having money or other property stolen,

(b)being defrauded,

(c)being put under pressure in relation to money or other property, and

(d)having money or other property misused.

Mr Gumm had sadly died and therefore this ended the Local Authority's legal duty to take steps to safeguard Mr Gumm under s.42. However, the Safeguarding Team did progress with a s.42 enquiry (although it should have been recorded as a non s.42 enquiry at that time) to seek wider assurance in relation to the care providers involved and any potential wider risks. (LCC's processes in relation to s.42 enquiries and more generally is explored below in the section on action by LCC). Proportionate enquires/fact-finding was undertaken (in so far as the council were able to do so given the circumstances) and no concerns were identified in relation to the services provided to the deceased.

Whilst the toxicology report had not been received at the time the safeguarding enquiry was closed, as no concerns were identified about the service provided by the provider, the outcome of the toxicology report would have had no bearing on whether the safeguarding enquiry should have been re-opened for the reason set out in the following paragraph.

LCC would reiterate that as LCC were not providing care to Mr Gumm. Mr Gumm, throughout any contact LCC had with him, had capacity to make his own choices. It was open to Mr Gumm therefore to make informed life choices to drink alcohol if he wanted to do so. Without any evidence to suggest that this was not a free choice, the carers would have no legal jurisdiction to intervene. Furthermore, this was a home environment not a care home setting. There was nobody else to safeguard in his home.

6. **Conflicting evidence was provided by Bluebird Care that:**
   Registered Manager (02/02/23 – "the only drink we pour for him is water, we never poured alcohol for him"
   26th November 2021 14.24 from carers log – "water and whisky provided on top of ongoing medication".
   EMAS report (12.4.22) "bottles of alcohol were found by his bed and enquired with the carers, however they believed that he doesn't drink a lot as he was unable to pour on his own".

We can only reiterate that LCC was not providing care to Mr Gumm at the time. LCC are not therefore in a position to determine whose evidence can or should be believed

nor could LCC judge whether Mr Gumm was capable or not of pouring his own drink or whether he was asking carers to do so as a capacitated person. Reopening the safeguarding enquiry would not have given LCC the ability to make such determinations. As this care was in his own home there was not deemed to be a risk to anyone else.

7. **Instead the s.42 reporter according to the live evidence of the principal practitioner of the Adult safeguarding team of the day, appears to have collated only limited information and closed the enquiry down prematurely without looking at material documents or even awaiting the toxicology report. At the very least it should be reopened to see if there was any missed opportunities from which lessons could be learnt and future deaths prevented and to embody the whole purpose of a s.42 assessment in deciding what action to take and protect the person in question. It being reiterated that this assessment was only commissioned after the deceased had been passed away.**

The s.42 reporter had made enquiries which determined that there was nothing which had led her to be concerned about how the provider had operated. For the reasons set out in paragraph 6 above, even awaiting the toxicology report, would not have allowed her to determine from these particular circumstances that the provider had acted inappropriately.

Actions taken

LCC has already reviewed its safeguarding processes in relation to matters where the safeguarding concerns are raised when the adult is deceased.

Pursuant to LCC's duties under s.42, a Local Authority is not required by law to carry out enquiries for those individuals who do not meet the criteria for safeguarding as set out in this section of the Act. In particular, the care act duty can have no application to a deceased individual as the purpose of the enquiry is to decide what action is to be taken **in relation to the individual** and by whom. In some cases, LCC may have had a safeguarding referral during the individual's life and appropriate information about LCC's safeguarding actions will be provided to the coroner.

In other cases, the safeguarding team may have had no involvement during the individual's lifetime but may have been notified on death. In these cases, it is not appropriate to undertake a s.42 enquiry.

However, if necessary, limited fact-finding enquiries will be made by the safeguarding team in order to ascertain whether further consideration of potential risk to others is required. This information is shared with the Commercial Team and, if appropriate, CQC, who will consider the information and decide any assurance actions, which may include if appropriate, a visit to the provider. Every contract for services with the council has its own contracts officer allocated to that provider. In the first instance, depending on the circumstances, it is likely that the contracts office will visit. However, the council also has significant other quality assurance methods which may be used to monitor and improve services and work with the regulator who has the power to take formal action or in the worst-case scenario work with the regulator, who has the authority to close down an unsafe provision.

Service Quality Reviews Meeting

These are monthly standing operational strategic review meetings. It is a multi-agency forum which monitors any provider who may be deemed to be high risk. In attendance at these reviews amongst others are usually the Commercial team, LCC Adult Safeguarding Team, Health, CQC, Health protection (public Health – LCC), NHS Continuing Health care etc. The provider will not be removed from this operational review until necessary improvements have been made. In addition, a fortnightly meeting takes place attend by LCC Adult Safeguarding Team, LCC Contracts Team (Commercial Team), ICB and CQC.

Quality and Safeguarding Board

This is a board comprising senior officers within the Council that will review any serious risks and agree and seek assurance regarding any appropriate action.

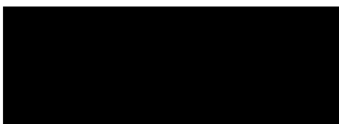
Meetings with CQC

The Head of the Commercial team also meets with CQC on a regular basis to discuss any cases of concern and facilitates any appropriate action.

Whilst therefore information may not be provided by the safeguarding team in these cases, the council has a tried and tested approach to the considering whether or not any other individuals may be at risk. If during this due diligence the council identifies an individual who is at risk, a safeguarding referral is then made to the council to see whether the individual meets the criteria for the opening of a s.42 enquiry.

We want to take the opportunity to reassure the coroner that whatever the process has been called, LCC are satisfied that appropriate assurances have been undertaken to see whether action does need to be taken by the wider council as a result of an individual's death.

Yours sincerely



Head of Safeguarding