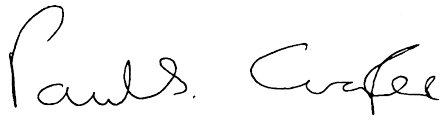
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted], Legal Services Manager Lincolnshire County Council**
1	**CORONER** I am Paul COOPER, HM Assistant Coroner for the coroner area of Lincolnshire
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.
3	**INVESTIGATION and INQUEST** On 14 December 2021 I commenced an investigation into the death of Colin Robert GUMM aged 65. The investigation concluded at the end of the inquest on 25 April 2023. The conclusion of the inquest was that: 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 earlier that day. Sadly despite treatment his condition deteriorated and he passed away the same day. A safeguarding referral was subsequently made.
4	**CIRCUMSTANCES OF THE DEATH** Please refer to above and below
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 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. 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. 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/monitor? 3.EMAS make there 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 none else in Adult Social Care making the same assessment during his lifetime? 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 admitted "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 risks to others. 6.Conflicting evidence was provided by bluebird care that : Registered Manager (02/02/2023) - "the only drink we pour for him is water, we never poured alcohol for him" "26th November 2021 14:24 from carer's log - "water and whiskey provided on top of ongoing medication" EMAS report (12/04/2022) - "bottles of alcohol were found by his bed and enquired with the carers ,however they believed he doesn't drink a lot as he was unable to pour on his own". If that is right somebody was pouring for him. Shouldn't all this have been picked up by the safeguarding assessment? 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 inquiry 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 to support and protect the person in question. It being reiterated that this assessment was only commissioned after the deceased had passed away.
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 June 20, 2023. 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. 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 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 by the Chief Coroner.

9	**Dated: 26/04/2023**  **Paul COOPER** **HM Assistant Coroner for** **Lincolnshire**