Kally Cheema LLB | Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

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14 November 2023

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Westmorland and Furness Council
CORONER

1 I am Robert Cohen HM Assistant Coroner for Cumbria

CORONER'S LEGAL POWERS

2 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

INVESTIGATION and INQUEST

On 16 November 2022 I commenced an investigation into the death of Gerald GOODWIN. The investigation concluded at the end of the inquest . The conclusion of the inquest was

3 Accidental death.

1a Multiple injuries consistent with being struck by a train

1b

1c

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CIRCUMSTANCES OF THE DEATH

4 Gerald Goodwin was 64 years old. He lived in Barrow-in-Furness, Cumbria. Mr Goodwin had been diagnosed with Alzheimer's Dementia in 2016 and observed to be unable to assess risk to his own safety in 2022. He also had a history of depression and anxiety. On 10th November 2022 Mr Goodwin was struck by a train whilst walking along the railway track in the vicinity of Dalton-in-Furness Station. His death was confirmed at 00:17 on 11th November 2022. A post mortem examination has confirmed that Mr Goodwin had

ingested a significant amount of alcohol prior to his death. It is more likely than not that he happened on to the railway track as a result of his dementia and alcohol consumption.

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 will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) The Liaison and Diversion of Lancashire and South Cumbria NHS Foundation Trust had contact with Mr Goodwin in September and October 2022. Liaison and Diversion Team members visited Mr Goodwin at home and concluded that he was at risk of self-neglect. They noted his appearance, his living conditions and the fact that he was not taking prescribed medication. On any view Mr Goodwin was vulnerable: he suffered from Alzheimer's dementia, and was thought to misuse alcohol. The Liaison and Diversion Team considered that there were safeguarding concerns in respect of Mr Goodwin and referred him to the Adult Social Care team of Cumbria Council. I understand that the team in question now forms part of Westmorland and Furness Council. Despite this referral from practitioners who had personally visited Mr Goodwin, it was rejected at triage on 5th October 2022. I am concerned that this indicates that an approach to triage is being taken which pays insufficient regard to the concerns of practitioners who had personally witnessed apparent safeguarding concerns.

(2) The witness statement on behalf of the Adult Social Care team explains that after the refusal to conduct a safeguarding enquiry, Mr Goodwin was nevertheless referred for the Social Work team to 'engage' with him. A social worker took steps to engage with Mr Goodwin and his family and concluded that a care assessment was appropriate. Despite this the 'Reablement Team' referred the case for closure indicating that they did not consider that such an assessment was not required. I am concerned that this indicates further circumstances in which the needs of a vulnerable person might be overlooked. After a social worker considered that a care assessment was needed the Reablement Team appear to be able to come to an alternative view and close the case without further discussion or rationale. In another case this might lead to a vulnerable person being disregarded.

(3) Fortunately, the Closure Team noticed that the Reablement Team were seeking to close a case in which another social worker had recommended a Care Assessment. They sent the case to the 'Short Term Allocation Tray'. This should have resulted in a referral but that did not happen. I am concerned that in a future case a referral might not be generated and a person's needs overlooked. The witness statement prepared by the Service Manager indicated 'we are looking at a way of ensuring that notifications requiring an action are only acknowledged once the task is complete'. This indicates that such work has not yet borne fruit and the risk still exists.

(4) Thereafter Mr Goodwin's case was allocated and de-allocated to a social worker within the space of one day, without anything being done. It is said that there is no note or explanation for this. I am concerned that, once again, the ability of a case to be allocated and deallocated within a short period and without anything having been done may enable a case to 'fall through the cracks'. Indeed, the referral for the care assessment was not ultimately actioned until 25th November 2022, 2 weeks after Mr Goodwin died.

(5) More generally, it is striking how many different teams and systems appear to co-exist and require mutual communication and cross referencing. I am concerned that the above

narrative demonstrates that those systems do not function effectively. I am concerned that this exposes other vulnerable adults to risk.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you Westmorland and Furness Council have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 10th February 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the family of Mr Goodwin.

8 I am also under a duty to send the Chief Coroner a copy of your response.

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.

14 November 2023

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Signature

Robert Cohen HM Assistant Coroner for