Miss K J Gomersal LLB | Acting Senior Coroner | Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

Tel: [redacted] | **Email:** [redacted]

Case Ref: [redacted]

20 February 2025

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Northumberland Childrens and Adults Safeguarding Partnership
CORONER

1 I am Mr 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 3 April 2023 an investigation was commenced into the death of Janet Scott. The investigation concluded at the end of the inquest. The conclusion of the inquest was

3 Janet Scott was 60 years old. She lived in Haltwhistle, Northumbria. Ms Scott had a complex medical history. She had been diagnosed with schizophrenia. She was diabetic. As result of her conditions Ms Scott struggled to care for herself in later life. She was very vulnerable.
Ms Scott lived in social housing. She required regular support with her mental and physical health needs. She struggled to maintain her home and ensure that it remained clean and safe. Ms Scott was at serious risk of self-neglect.
In 2022 attempts began to rehouse Ms Scott. Unfortunately, it was not easy to identify a suitable alternative address in the small area in which she was willing to live. As a result, she remained at the same address until a scheduled move in March 2023.
On 7th March 2023 Ms Scott's Community Psychiatric Nurse ('CPN') contacted Adult Social Care. She had been allowed entry into Ms Scott's home and was very concerned. She described 'squalor': a property full of rubbish bags, with a build-up of food parcels that Ms Scott was not using. On that day, Ms Scott had been kneeling when she answered the door. On the next day, Ms Scott was visited by her support worker. She was observed to be dishevelled, exhibiting poor personal hygiene and struggling to walk.

Following these encounters, there was a failure to activate multi-agency safeguarding procedures. Multiple attempts were made to contact ASC over the coming days, but these were not responded to with sufficient speed or rigour. Ms Scott was visited on 20th March 2023 but no immediate risk to her was recognised.
Ms Scott was found at home, unresponsive, on 28th March 2023. She had developed sepsis. Ms Scott was transported to the Cumberland Infirmary, Carlisle, by ambulance. She died there on 30th March 2023. Ms Scott's death was confirmed at 17:50.
It is more likely than not that Ms Scott's self-neglect, her living conditions in the last weeks of her life, and the very limited medical assistance provided to her in those weeks caused or contributed to Ms Scott's death.
Ms Scott's death was contributed to by neglect, being the failure to procure basic medical care for her after concerns were raised on 7th March 2023.

1a Sepsis

1b

1c

II Diabetes Mellitus and Schizophrenia

CIRCUMSTANCES OF THE DEATH

Ms Scott had a serious tendency toward self-neglect. She was a 'hoarder' and her living conditions were seriously unsanitary. She was also without a functioning boiler for 18 months after her gas supply was capped.

Prior to Ms Scott's death there were numerous occasions on which her self-neglect was apparent to different agencies. Although it is true that Ms Scott was often unwilling to
4 accept help, I heard evidence of several occasions on which there had been missed opportunities to provide assistance.

To their substantial credit, many of the agencies involved in Ms Scott's situation provided evidence to me of the steps they have taken to avoid a repeat. There was a consensus that more could and should have been done to adopt a multi-agency approach to safeguarding.

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. –

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(1) Although individual agencies referred me to training they had provided to staff since Ms Scott's death, I also received evidence that, for instance, the GP surgery might not raise a safeguarding referral if the same circumstances were repeated because social services had already been informed. This leads me to be concerned that the message that 'safeguarding is everyone's responsibility' has not been taken on board. I am concerned that future cases will occur in which a multiagency approach is not adopted or that individuals will not make safeguarding referrals because they assume that other agencies are already aware of the issue.

(2)

(3)

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you **Northumberland Childrens and Adults Safeguarding Partnership** 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 18th April 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to each of the Interested Persons.

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.

20 February 2025

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Signature

Robert Cohen HM Assistant Coroner for Cumbria