Kally Cheema LLB | Senior Coroner| Cumbria

Fairfield, Station Road, Cockermouth, Cumbria CA13 9PT

[redacted]

[redacted]

5 October 2021

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Senior Legal Officer, Adult Safeguarding, Cumbria County Council

1 **CORONER**

I am Dr Nicholas Shaw, 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

3 An inquest was opened on 1st June 2021 and concluded at a final hearing on 5th October 2021. The short form conclusion reached was one of Self Neglect.

CIRCUMSTANCES OF THE DEATH

4 **Charlotte Duffield was 40 years old, her body was discovered when police forced entry to her home on 4th February 2021 in response to concerns that Charlotte had not been seen for several weeks. It appeared she had been deceased for a significant period of time. Evidence heard at the inquest suggested that she lived a reclusive lifestyle and was not caring for herself, particularly after her father, with whom she lived, had died 3 months earlier. Due to advanced decomposition a pathologist was unable to determine the**

exact cause of death, however there were no suspicious circumstances to suggest death was other than natural

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) On 3rd November 2020 Police officers attend Charlotte's home following a telephone call from her aunt expressing concern for her wellbeing. The Officers
5 were concerned about the state of the property, Charlotte's clothing, her lack of emotional response and that she may not have access to money following the sudden loss of her father, Reviewing their report DS [redacted] of Cumbria Constabulary made a referral to Adult Social Care on 5th November. Evidence seen at the inquest indicates that on receipt of the referral 3 attempts to telephone Charlotte were made on 6th, 9th & 10th November. As there was no reply a letter was sent asking her to contact them. There is a note that her case was discussed at a multidisciplinary meeting on 9th December 2021 but no further action seems to have been taken.

(2) Charlotte was referred due to significant concerns for her safety but no safeguarding action seems to have been taken. I am particularly concerned that after her failure to respond to attempted telephone contact no physical effort was made to visit her in person.

ACTION SHOULD BE TAKEN

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

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report,
7 namely by 3rd December 2021. 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. I have also sent it to The Chief Constable, Cumbria Constabulary, Dr [redacted], Duke St Surgery, Barrow-in-Furness
8 and the family of Charlotte Duffield who may find it useful or of interest.

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.

5 October 2021

9 Signature