IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Beryl Varcoe
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Rob Moran Chief Executive Elmbridge Borough Council Civic Centre High Street Esher Surrey KT10 9SD
1	**CORONER** Ms Anna Crawford, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INQUEST** An investigation into the death of Mrs Varcoe was commenced on 4th May 2016 and an inquest was opened on 21st September 2016. The inquest was resumed on 21st March 2017 and concluded on 28th April 2017. The medical cause of death was: 1a – Lobar pneumonia The inquest concluded with a narrative conclusion.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Varcoe had a community alarm installed at her home address due to concerns about her falling when she was alone. The alarm was installed by Elmbridge Borough Council's Community Alarms Service.

	The court heard evidence that the alarm system was a Chubb alarm and comprised a base unit and a pendant to be worn around the service user's neck. In the event that the service user presses the pendant, the base unit automatically dials a monitoring centre, which is staffed 24 hours a day. The court was told that the pendant and the base unit communicate by way of radio signals, which can potentially be interfered with by objects such as walls, piping and electrical wiring. The installer, who carried out both the initial installation of Mrs Varcoe's alarm on 13 May 2013, and the subsequent upgrade on 9 December 2015, did not carry out any tests to ascertain whether Mrs Varcoe's bedroom was within the range of the base unit, which was located in one of her reception rooms. On the evening of 18 April 2016 Mrs Varcoe either fell or collapsed in her bedroom. She repeatedly pressed the pendant but it did not activate the alarm due to a number of impediments to the radio signal. As a result of those impediments, her position was outside of the range of the base unit. She remained on the floor until she was found by friends and family at approximately 4pm on 19 April 2016. She was taken to St Peter's Hospital where she was diagnosed with pneumonia and chest sepsis, which had developed as a result of the extended period that she had remained on the floor. Despite treatment, her condition deteriorated and she died at the hospital on 21 April 2016. The period that Mrs Varcoe sent on the floor and the resultant delay in her admission to hospital made a material contribution to her death.
5	**CORONER'S CONCERNS** The court heard evidence from [redacted], the head of Elmbridge Borough Council's Community Alarms Service, who told the court that the service has 1,700 clients and two installation officers, who are responsible for fitting and upgrading alarms in clients' homes. [redacted] told the court that it was his expectation that the installation officers carried out thorough range testing when fitting and upgrading alarms, to check that the pendant was capable of activating the base unit from all internal and external parts of a property. The court also heard evidence from the particular installer who fitted and upgraded Mrs Varcoe's alarm. He gave inconsistent evidence with regards to his practises in respect of range testing. However, having

	considered the entirety of his evidence, the court is concerned that it was his practice only to range test pendants in those parts of the service user's home, which they used most regularly and in which they felt most vulnerable. The court was told that the installation officer who fitted Mrs Varcoe's alarm has now retired. The court was also told that the Community Alarms Service has developed a number of new procedures, which are to be introduced imminently, with the aim of ensuring that thorough range testing is documented at the time of each alarm installation or upgrade. However, the court is concerned that a significant number of the service's clients currently have alarms, which were fitted prior to the introduction of the new procedures and by the same installation officer who fitted Mrs Varcoe's alarm. As such there is a risk that those service-users may have alarms which do not function throughout the entirety of their homes. The **MATTERS OF CONCERN** are: Elmbridge Borough Council's Community Alarms Service has a significant number of clients who currently have alarms, which may not have not been thoroughly range-tested and may not function throughout the entirety of the service-users' homes.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. [redacted], Mrs Varcoe's son 2. [redacted], Head of EBC Community Alarms Service 3. [redacted], General Manager, Chubb Community Care

	4. The Chief Coroner In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: **ANNA CRAWFORD** **DATED this 3rd day of May 2017**