Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

By Email Only

Dear Madam

EP INQUEST - REGULATION 28 REPORT RESPONSE

Thank you for your letter of 8 January 2021. We are grateful to you for bringing your concerns to our attention following the inquest hearing of Mrs Elizabeth Pamment at which Peabody were an Interested Person. [REDACTED] the Older People's Housing and Support Manager and [REDACTED] Scheme Manager attended the inquest to provide evidence on behalf of Peabody.

Background to Peabody's service at Alleyn House

Alleyn House is a sheltered housing scheme in Islington which is part of Peabody's Whitecross Street Estate and is home to 31 residents. Peabody own and manage 34 sheltered housing schemes in London. These provide 992 units of accommodation for tenants who are over 55.

The sheltered housing scheme provides for independent living. Each tenant has a self-contained flat with their own front door and they are free to come and go as they please. Peabody provides a 'Scheme Manager' who is there during office hours to respond to emergencies, deal with resident queries, to prevent social isolation by organising events and activities and to provide an enhanced housing management service by assisting with organising repairs and general building management.

Peabody does not provide care, but housing related support via the Scheme Manager (who is on site 35 hours a week – 9am to 5pm Monday to Friday). The people residing at the service (the residents) are generally independent and have full capacity. For the avoidance of any doubt, there is no care support service on site unless tenants make their own arrangements directly with a care provider. As Peabody do not provide care or any healthcare regulated activities at Alleyn House, this sheltered housing scheme is not a CQC regulated service.

We supply telecare to residents in the form of a 'Careline'. This provides the opportunity for residents to call for help in an emergency. The service can be accessed through alarm/response call points and intercoms which are positioned throughout the accommodation in both residents' flats and in communal areas. The system can also be accessed through wearable devices such as watches and pendants where requested by residents. If an alarm is triggered, it goes to the staff on site during office hours and to the out of hours Careline provider out of hours. This out of hours Careline service is provided by the Local Authority.

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When the alarm is triggered the Scheme Manager during working hours or the Careline provider out of hours will decide whether the call requires an emergency response from them or from the emergency services. Essential resident information (information such as name, address, age, key contacts including next of kin, medication, health issues, ethnicity) is collated at sign up to the service by Peabody staff and transferred to the Careline provider. Peabody staff review customer data quarterly or if there is a change in the tenants circumstances. The Scheme Manager updates the Careline provider if anything significant has changed.

The out of hours Careline provider for Alleyn House is Islington Telecare. They are the only Careline Provider we work with who did not provide a standardised form to complete containing resident information. The custom and practice was to provide information about residents to Islington Telecare by email. This practice had not resulted in any previous concerns about emergency response provided by Islington Telecare.

Mrs Pamment

Mrs Pamment resided at Alleyn House for over 4 years, from June 2016 to August 2020. The support agreement in place with Peabody was for Mrs Pamment to receive a call every morning when the Scheme Manager was on site. Mrs Pamment's daughter, [redacted] provided support with shopping, and household tasks such as cleaning, and visited her mother most days except Fridays.

Mrs Pamment was issued with a wrist pendant by Peabody in addition to the emergency pull cords in each room throughout the flat which enabled 24 hour emergency help.

Mrs Pamment lived independently, she wore her care line pendant for emergencies but was also able to contact the Scheme Manager during office hours directly if she had any particular queries or concerns.

Timeline of events leading up to Mrs Pamment's death

On the 12th August 2020 Mrs Pamment had a fall in the night and used her pendant to call Islington Telecare. Islington Telecare visited at around 22.48 and reported that they found Mrs Pamment on the floor. They assisted her off the floor, helped her back into bed and left. Later that night or the following morning she fell again and was unable to call for assistance.

The next morning [redacted] the Older People's Housing and Support Manager was providing cover for the Scheme Manager who was on leave. [redacted] is familiar with the service and the residents. As per our standard practice on arrival at the service [redacted] commenced call checks to each of the tenants. While carrying out these checks [redacted] noted that a resident in another flat was unwell. She attended to this resident who required an ambulance. [redacted] waited with the resident until the ambulance arrived. Once the customer had been seen by the paramedics, [redacted] carried on with her checks and contacted Mrs Pamment's flat at 10.30am.

No answer was received from Mrs Pamment and [redacted] therefore entered the flat and found Mrs Pamment on the floor and extremely unwell. [redacted] immediately called for an ambulance and her daughter who lived nearby and was very involved in Mrs Pamment's support. Mrs Pamment was admitted to hospital and sadly passed away a few days later.

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Review undertaken by Peabody

Following the incident, [redacted] as the Older People's Housing and Support Manager, reviewed actions required with her Head of Service. At that time no apparent failure to follow procedures nor concerns regarding the response to the incident were identified. The review focussed on the actions taken by the staff member when she arrived at work and the response when Mrs Pamment was found unwell in her flat.

In terms of concerns raised by Mrs Pamment's family at the time; the family was in contact with [redacted] after the event and questioned the actions of Islington Telecare. The family asked [redacted] some questions about Islington Telecare's visit and [redacted] had acted as an intermediary getting responses to those questions. We were not contacted again by either Islington Telecare or the family on this matter and so were not aware of any further issues or specific concerns in regards to Peabody's actions.

The question of whether an ambulance should have been called following Mrs Pamment's first fall became the focus of our reflection in preparing for the inquest. We were not alerted in advance to concerns about our procedures and consequently our witnesses attended without representation.

Matters of Concern raised by the Coroner and Peabody's response

1. There was no record made by Peabody of the instruction given by Mrs P and her family.

It is agreed that the instruction to call Mrs Pamment's daughter in the event of an incident was not noted on Mrs Pamment's case file so we cannot confirm if this instruction was given by Mrs Pamment or her family. The staff member dealing with Mrs Pamment's admission unfortunately does not recall such an instruction due to the time passed since she moved in (over four years ago).

Our sheltered housing residents have capacity and can exercise choice. Our practice and protocol is to ask residents if they wish their next of kin to be contacted as and when an incident occurs. In a situation where the resident was incapacitated the staff member would always contact the resident's next of kin/emergency contact and the emergency services where appropriate. A resident's next of kin would also be contacted where we are unduly concerned about a resident, using our best judgment.

In order to address the concern raised, we have amended how we share residents' information with Islington Telecare to ensure that any specific requests are captured with the resident's permission and noted to the Careline provider. We have also included a section that explains to the resident that if Careline is alerted out of hours and the call requires an emergency response then the careline provider will always contact their NOK unless the resident specifically opts out of that procedure.

All essential and required information will now be captured in a standardised 'Resident Information Form'. We have appended this form to our response.

Our service manager has made arrangements to meet all other careline providers we commission to review the other forms in use to see if they could be improved. The outcome of those discussions will further inform our procedural review.

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2. There was no Peabody protocol for the taking and recording such an instruction.

It is Peabody's protocol to record essential information about the resident within our case management system. All residents are assessed as part of the moving in process and there is a continuous process of review throughout their tenure. Information captured includes relevant history, additional needs, next of kin details and other essential information such as medical information.

Not all information held about the resident is appropriate to share with the Careline provider and therefore essential information, until this case, was either exchanged by form or by email in the case of Islington Telecare.

As per the previous action above, we will now always use a comprehensive form to exchange essential information with Careline providers and this will include any special instructions from the resident.

3. The Peabody scheme manager checked personal details with tenants from time to time, but was never advised to obtain such an instruction regarding when to call a family member

Peabody's procedure requires our staff to review all resident's personal details on a quarterly basis or as and when the residents circumstances change. Significant changes are shared with the Careline provider accordingly. This activity is reviewed by the Area Managers as part of their quarterly scheme checks. This procedure was explained during the inquest.

As set out above, residents will now be informed that Careline will always contact NOK in an emergency unless they opt out of that instruction. Further to that they will be explicitly asked whether there are other special instructions they want shared with the Careline provider. We have produced a **Resident Information Form** to capture all required information.

4. Peabody gave tenants' personal details to Islington Telecare, but kept no record of what information they had passed on to the alarm monitoring company. Witnesses in court had no idea what Islington Telecare had been told to do in the event of an emergency with Mrs P.

We did not have this information available for the inquest as we were previously asked only to provide a statement on Mrs Pamment's accommodation and on the events of the day Mrs Pamment was found unwell. Staff were not informed prior to the inquest that this information would be required and no requests for further information were made to us beforehand, other than to provide the witness statements as already noted.

In sheltered housing we have a set of information that we hand over to all Careline providers. We informed the inquest that this information would typically include name, address, age, key contacts including next of kin, medication, health issues and ethnicity.
This information is usually requested on a standard template provided by the Careline providers. At that time, Islington Telecare did not provide a template for this purpose. As confirmed above, we have now produced a standardised template form which will be completed for each resident and we are meeting with Islington on the 15th March to further discuss the revised form and procedure.

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5. Despite Mrs P's death occurring in August 2020, it was not until today at inquest that Peabody staff considered making any changes to their procedures.

We were not aware of the concerns raised by the family until our attendance at the inquest and our own review had not identified any specific procedural or staff failings. Previous incidents had also not highlighted gaps in our practice.

We accept that our procedures will be improved by a more formalised exchange of information with Islington Telecare and by specifically giving residents the opportunity to have special instructions captured by us and passed on to the out of hours service. Actions associated with this improvement are either complete or set with an implementation date.

A meeting is due to take place on 15 March 2021 between [redacted] in her role as Service Manager and her counter-part at Islington Telecare whereby the roll out of the Resident Information form is to be discussed so that the information on our residents provided to them is standardised. Forms for all residents of Alleyn House are to be completed by 15 March and forms for residents of all other schemes serviced by Islington Telecare are to be completed by end of March 2021.

Discussions with other careline providers regarding procedural changes are to take place by the end of April 2021.

Summary of Actions taken/ to be taken by Peabody

- A standard Resident Information Form for Careline providers has been produced (attached) which captures appropriate information including specific instructions regarding family/NOK contact in emergency and non-emergency situations.
- A new procedure will be implemented that ensures that specific questions are asked of new tenants and existing tenants at review and fully shared with all Careline providers supporting Peabody residents. We will review all current resident information to ensure any special instructions/arrangements are logged and communicated to the relevant Careline provider.
- As part of wider work and part of a review of Careline service, we are installing key safes for each flat within Peabody's Older Peoples' Social Housing services to assist with access for emergency services or appropriate persons.

We attach a copy of our Action Plan following this inquest for your reference.

We have also met with Islington's Safeguarding Lead to discuss this case and there have been communications between us and Islington Telecare since the inquest. As set out above, Peabody's Head of Service has meetings arranged with Islington Telecare and other telecare providers to review our learning from this matter, which are to take place by the end of April 2021.

In terms of the inquest proceedings, it is also recognised that the witnesses from Peabody were not appropriately supported when responding to and attending the inquest. Therefore Peabody is also implementing a new process whereby there is appropriate senior management oversight for involvement of Peabody's staff in any future inquests.

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We are concerned that the Coroner was not able to raise her concerns with Peabody on an informal basis and request further information from Peabody in the first instance to give us an opportunity to respond before a Regulation 28 report was considered; Peabody does however recognise the learning and the room for improvement in regards to its record keeping, the sharing of information regarding its residents to careline providers and communicating its expectations of careline providers. We hope the above information provides the necessary assurance in regards to steps being taken by Peabody resulting from this matter.

Please do let me know if we can assist you any further and we would like to again offer our sincere condolences to Mrs Pamment's family.

Yours sincerely

[REDACTED]

Group Director Care and Support

CC:

[REDACTED], Islington Safeguarding Lead
[REDACTED], Regulator of Social Housing

Encl.

- Appendix 1 - Resident Information Form
- Appendix 2 - Peabody's Action Plan