Regulation 28: Prevention of Future Deaths report

Elizabeth PAMMENT (died 16.08.20)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive** **Peabody Trust** **45 Westminster Bridge Road** **London SE1 7JB**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 20 August 2020, I commenced an investigation into the death of Elizabeth Pamment aged 81 years. The investigation concluded at the end of the inquest earlier today. I made a determination at inquest, a copy of which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Elizabeth Pamment lived in Alleyn House, sheltered accommodation provided by Peabody Trust. She died from pneumonia following two falls on the same night, the second of which resulted in her lying alone on the floor, increasingly unwell, until she was found mid morning by a Peabody area manager.

5	**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. When Elizabeth Pamment moved in to Alleyn House in 2016, she and her family gave explicit instructions that, in the event of any emergency, her daughter living very nearby was to be contacted. This was discussed in some detail and agreed to by Peabody staff. Mrs Pamment wore a pendant to enable her to summon assistance in the event of a fall or other emergency. She used this for the first time on the evening of 12 August 2020. Staff from Islington Telecare attended and helped her back to bed. However, they were unaware of the standing instruction to call her daughter and so did not do this. The consequence of this was that, when Mrs Pamment fell again the same night and was unable to get up or call for help, she had to spend the night alone on the floor getting more and more unwell. Peabody staff explained the following in evidence. 1. There was no record made by Peabody of the instruction given by Mrs Pamment and her family. 2. There was no Peabody protocol for the taking and recording such an instruction. 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. 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 Pamment. 5. Despite Mrs Pamment's death occurring in August 2020, it was not until today at inquest that Peabody staff considered making any changes to their procedures. If Islington Telecare had been instructed always to contact Mrs Pamment's daughter in the event of an emergency, [redacted] would have been rung as soon as the team had been sent out to Elizabeth

	Pamment, and in fact would have arrived before them. She would then have stayed and looked after her mum. It is unclear whether that would have saved Mrs Pamment's life but it is possible, and it certainly would have significantly improved her physical and emotional comfort.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 8 March 2020. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the following. • [redacted], Elizabeth Pamment's daughter • [redacted], chief executive, Islington Council • Care Quality Commission for England • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 08.01.21 *ME Hassell*