

HM Coroner ME Hassell
Inner North London
Poplar Coroner's Court
127 Poplar High Street
London
E14 0AE

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26 January 2023

Dear HM Coroner Hassell

Regulation 28 Report following the inquest into the death of Reginald Cauthery

We write further to the Regulation 28 report received on 16 December 2022 made following the inquest into the death of Reginald Cauthery.

We are sorry to learn of the tragic death of Reginald Cauthery and the matters of concern as follows:

- 1) There was no review of the telecare service provided to Mr Cauthery despite the agencies working with him being aware of his increased fire risk and deteriorating mobility.
1. (2) The ability of frail and vulnerable people to get urgent help in a fire situation will often depend upon other people recognising that a smoke alarm has triggered and calling the Fire Brigade. This raises particular problems if the person lives alone and their smoke alarm is not connected to their telecare system.
2. (3) If Mr Cauthery's smoke alarm had been connected to his telecare system, the call would have been answered as a priority. In addition, the call handler would not have spent several minutes seeking confirmation that the smoke alarm was going off before making a 999 call.

We have contacted the regulated provider, Best Choice Global Limited provider and discussed lessons learnt with them. The regulated provider was reliant upon telecare 'experts', fire service and commissioners to ensure the telecare equipment was appropriately linked to the fire service.

However, the matters of concerns highlighted in the Regulation 28 report relate to services outside our scope of regulation. We do not regulate the fire service or the

telecare service and therefore we have no powers to prevent future deaths in relation to these services.

If you identify any further assistance that the CQC is able to provide, please do not hesitate to contact us with any questions.

Yours sincerely

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Interim Deputy Director - London