Coroner ME Hassell
HM Senior Coroner
Inner North London

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. Jeremy Quin MP,
   Minister of State for Crime, Policing and Fire
   Home Office
   2 Marsham Street
   London
   SW1P 4DF

2. Rt Hon Therese Coffey MP
   Secretary of State for Health and Social Care
   Department of Health and Social Care
   39 Victoria Street
   London
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3. [redacted]
   Chief Executive
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   Chief Executive Officer
   Telecare Services Association
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5. [redacted]
   Managing Director
   UK Telehealthcare
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	6. [redacted] Executive Director CECOPS 71 Church Street Great Missenden HP16 0AZ.
1	**CORONER** HM Assistant Coroner Sarah Bourke Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
2	**CORONER'S LEGAL POWERS** 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.
3	**INVESTIGATION and INQUEST** On 9 March 2022, Senior Coroner Hassell commenced an investigation into the death of Reginald Cauthery, aged 82 years. The investigation concluded at the end of the inquest on 19 August 2022. The conclusion of the inquest was that the medical cause of Mr Cauthery's death was: 1a) Multi organ failure; 1b) 36.5% burns to the body; 2) chronic obstructive pulmonary disease, cardiac failure, and ischaemic heart disease. I returned a short form conclusion of Accident which stated as follows: *Mr Cauthery was identified as having an increased fire risk due to smoking. As he was frail, his ability to react to and escape a fire was significantly reduced. Smoke alarms were fitted at his home, but these were not connected to the telecare monitoring system in his home. A smouldering fire started in the electrical motor of his bed on 21 February 2022. The smoke alarms activated but the Fire Brigade was not contacted for at least 10 minutes after the alarm first went off. Mr Cauthery sustained extensive burns and died in hospital the following day.*

4	**CIRCUMSTANCES OF THE DEATH** Mr Cauthery was frail with limited and deteriorating mobility. He had some problems with alcohol and used medication which made him sleepy. He lived alone with the support of carers and family members. In July 2020, he was discharged from hospital with a motorised bed. Mr Cauthery's bed was serviced in accordance with the Manufacturer's servicing schedule and no faults were ever reported. Additionally, a telecare pendant alarm system was fitted in his flat. The system was linked to a call centre which would alert relatives in the event of a call. In September 2020 a person-centred fire risk assessment found that Mr Cauthery's mobility was limited to transferring between his bed and his commode. The assessment also found that he was at increased risk of fire due to smoking in bed and that he would be less able to react to fire or escape due to his poor mobility. The Fire Service undertook a Home Fire Safety Visit and fitted smoke alarms. Mr Cauthery was also issued with fire retardant bedding. The smoke alarms were not connected to the telecare system. His carers were of the view that Mr Cauthery needed to be supervised at night, but Mr Cauthery did not agree. A Care Act assessment carried out in December 2020 noted factors relevant to fire risk and referred to an incident when the smoke alarm had triggered due to Mr Cauthery falling asleep whilst smoking. The assessment did not review the telecare arrangements. In December 2021, the Fire Brigade were called to a small fire at Mr Cauthery's flat which was caused by smoking materials. The Fire Brigade made a safeguarding referral. The Local Authority decided to refer Mr Cauthery to a Complex Case Management Social Worker but there were no changes to his care package or the equipment provided. The telecare arrangements were not reviewed. Around 9pm on 20 February 2022, a neighbour thought they could hear a car alarm going off. At approximately 9.30 pm the neighbour realised that the alarm was coming from Mr Cauthery's flat. The neighbour could not smell smoke but made further checks and saw smoke coming from Mr Cauthery's window. The neighbour made a 999 call at 9.38 pm. Around the same time, telecare records show that Mr Cauthery pushed his pendant alarm. The telecare call was not answered until 9.41 pm. The telecare call handler did not make a 999 call until 9.47 pm as they spent several minutes trying to obtain confirmation that the smoke alarm was going off from Mr Cauthery and his nominated relative. The Fire Brigade arrived on scene at 9.43 pm. Firefighters entered the property and found Mr Cauthery lying on the floor next to his bed. Mr Cauthery was the only person in the property. Mr Cauthery sustained full thickness burns to his face, torso, arms, and legs which affected 36% of his total body surface area. Mr Cauthery died the following day. An investigation was carried out by the London Fire Brigade who found that the fire was most likely to have been a smouldering fire within the motor unit for his bed mechanism. Had the fire instead been started by a lit cigarette, this would also have been a smouldering fire. In either event, smouldering would have generated smoke for several minutes before a flame developed.
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 could 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) 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. (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. (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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 5 December 2022. 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 Chief Coroner and to the following Interested Persons: • Family of Reginald Cauthery • London Borough of Hackney • London Fire Brigade • Best Choice Global Limited • Millbrook Healthcare Group 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.
	Sarah Bourke **HM Assistant Coroner** **4 October 2022**