In the matter of a response to a prevention of future death report arising from the inquest into the death of Miss A. Summers.

1. This is the response to the Prevention of Future Death Report (PFDR) issued by HM Assistant Coroner Mr Bucket dated 6 June 2024, following his inquest of the same date, into the death of Miss Anoush Summers. The PFDR is a public document. This response is provided to the Court as directed, by Supreme Care Services Ltd, the care provider. They are a domiciliary care agency who provided personal care to the deceased.

2. The care provider was made aware by the service user that her wrist pendant was not working. The service user had full capacity and was able to raise concerns and communicate her wishes.

3. The pendants have a testing mechanism where a service user can check to see if it is working. It is also understood that the third-party telecare provider (Livity Life), which has full responsibility for the provision and working order of any such pendant, including maintenance and repair, undertakes remote routine testing of devices of their own volition.

4. The telecare provider ought to have been aware that the pendant was not working through its own testing.

5. The role of the domiciliary care provider was not to supply, maintain, repair or replace a faulty wrist pendant. No contractual arrangements or requirements were made to that effect.

6. It is understood that the telecare provider was not made an Interested Person in the inquest under section 47 of the Coroner's and Justice Act 2009 and it would have been preferable given that they engage the threshold of *sufficient interest,* in the proceedings which focused on the pendant.

7. The pendant does not alert or summon the care provider. It is a direct link to the telecare provider.

8. The provision of the pendant arises from Livity Life care as the telecare provider. As such, it is incumbent upon them to supply, routinely monitor and replace pendants if they become faulty. The telecare provider was correctly informed by the service user that her pendant was faulty. The service user was capable of reporting this. She was assisted by the care provider in doing so and it was reported immediately.

9. The care provider correctly recorded that the service user had concerns about her pendant not working on 6 January 2024.

10. As was noted in open court, the witness statement of the local authority, Miss S Bristol, (paragraph 72), records *"the service user was assisted by the carer with reporting the issue directly to the telecare company. The report of a faulty wrist alarm was received by the telecare company on 8 January 2024. Repairs by the telecare company are actioned within five working days, subject to being able to reach the named contact (three attempts are usually made to reach the name contact). Unfortunately, the company was unable to make contact with the next of kin until 14 January 24."* Although the statement says that the report was received by the telecare company on 8 January 2024, it was actually reported on 6 January 2024.

11. The statement also records, *"the case notes and my own assessment show that Ann demonstrated capacity in relation to her decision-making about her care and support needs. As it was and wishes to remain her home, ASC facilitated Ann's wishes and provided her with support they were able to."*

12. It is not known why the telecare company were not asked or did not provide evidence to the inquest regarding their role in the provision, testing, maintenance, repair and replacement of the pendant, as well as their inability to contact the

deceased within their own timeframes and what efforts they made. It is not known what they do in circumstances of non-contact.

13. The apparent agreed protocol for repairs, which is outside the remit of the care provider, shows there is an agreement in place with the commissioning authority and the telecare provider, as to timeframes. Here, there is a five working day turnaround to replace pendants, unless it is urgent, when as it turns out, there is a service standard for it to be done within 2 working days. This has been found out subsequent to the inquest. This appears to mean if a faulty pendant notification falls over a weekend, the accepted response time as a minimum might be seven days.

14. Once the information had been given to telecare provider it was incumbent upon them to make contact with the service user, her family, the local authority who commissioned the pendant and indeed her care provider. No evidence appears to have been called as to why the telecare provider failed to make contact with the service user or somebody on her behalf. It is not known what they did with the referral or why if they did attempt all reasonable telephone contact, they did not post a letter to the service user and/or contact the commissioning local authority. These are not matters of regulation by a care provider. The care provider does not subsume the responsibility of the telecare provider or commissioner.

15. As a result of the issue surrounding the telecare provider, the care provider has reviewed all of its service users with pendants and engages in weekly testing of them. This is a robust approach and one not previously asked of them.

16. It remains the role of the telecare provider to monitor and replace any faulty pendants within the terms of its contractual arrangements with the funding authority and it is also their responsibility to routinely test pendants.

17. As an abundance of caution, given the uncertainty surrounding the commissioning of telecare pendants and their role with the local authority, all faulty pendants are

notified to the local authority so they can take primacy to act and ensure that a repair or an alternative is commissioned.

18. It is understood from the evidence heard, that the local authority said that it would have commissioned care on a one-to-one, twenty-four hours a day basis, for service users in the situation of a faulty and unrepaired pendant. This was not information made known to the care provider nor is it thought that it would be known to the telecare provider. Had it been the position, then the telecare provider would have, on being unable to make contact with the service user or anybody on her behalf, notified the local authority who would have put in place an enhanced care package. This issue arose post inquest and was requested but no one-to-one on a twenty-four hours a day care package was engaged. It is therefore relevant for the local authority to inform the care provider of action to be taken during knowledge of and or repair a faulty pendant.

19. The responsible telecare provider, it is understood, continues to undertake remote testing of its devices to ensure that the equipment remains working, and any faults can be actioned.

20. The livitylife.co.uk website says the following, "*Our successful partnership with the London Borough of Hackney delivers an Integrated Telecare Service encompassing Call Monitoring, provision of a 24/7 Telecare Response Service, and Telecare Equipment provision including supply, installation, maintenance, testing, reprogramming and decommissioning with follow-up visits to help keep residents safe and independent home.*"

21. The hackney.gov.uk help at home website says that the service time frames are

"Service timeframes

TEL aims to:

- *replace or repair any TEL equipment within 2 working days when the need is urgent*
- *replace or repair TEL equipment if needed, within 5 working days in non urgent circumstances*

Livity Life provides:

- *TEL repairs and maintenance*
- *TEL emergency responders for Hackney*
- *monitoring alarm service*

To report an issue with your TEL equipment press the button on the wearable device or base unit to speak to the 24 hour Monitoring centre. If this is not possible, contact the Haggerston based team by calling [redacted], or emailing [redacted].

Our council based TEL team:

- *review referrals*
- *order equipment*
- *provide advice*
- *work with Livity Life to coordinate TEL services*

22. It does not denote what constitutes urgent and non-urgent provision nor does it note to contact the local authority separately.

23. In the circumstances, a telecare pendant is provided by the telecare provider who is responsible for its provision, repairs, testing and maintenance as commissioned by the local authority.

24. In this matter, the telecare provider was informed of the faulty pendant and for reasons yet to be understood, did not contact the service user in any way, nor the local authority nor the care provider.

25. As a result of concerns arising and to maintain high standards of care, the care provider has undertaken a review of all service users' pendants and undertakes weekly checks of them. It reports faults to the responsible telecare provider and commissioning local authority. It does not subsume the responsibility of the telecare provider nor the local authority in relation to this.

26. Going forwards, it is reasonable to expect that if the telecare provider identifies faults during routine testing, that it contacts the care provider, service user (and/or their family) and the local authority so that measures can be put in place to mitigate

against risk. It would also be helpful if the telecare provider and the local authority provided clear flowcharts on the actions that should be taken by the various stakeholders when equipment is found to be faulty.

27. The care provider takes service user safety very seriously and continues to put service users first.

Supreme Care Services Ltd

2 August 2024