Quality · Safety · Innovation

Edwin Buckett
Assistant Coroner
Inner North London
Poplar Coroner's Court
127 Poplar High Street
London
E14 0AE

24 July 2024

Dear Edwin Buckett,

I am writing in reference to the Regulation 28: Prevention of Future Deaths report for Anoush Summers (died 14.1.2024), as enclosed.

For incidents involving Regulation 28 notices where Technology Enabled Care (TEC) has played a part in any failures, whether through service or equipment, it is customary for the TEC Services Association (TSA) to provide commentary as the independent industry subject matter expert.

About the TSA:

The TSA is the industry body committed to transforming the TEC sector by strengthening partnerships, leveraging data, and empowering people, while addressing the demands, scope, and opportunities in Technology Enabled Care.

We strive to ensure the quality and safety of TEC by setting and developing standards and providing independent and trusted audit and certification through our wholly owned subsidiary, TEC Quality Ltd, an accredited body by the United Kingdom Accreditation Service (UKAS).

We offer support and knowledge-sharing to members aiming to improve the delivery of TEC services, grow their business, or enhance their impact on the TEC sector.

About TEC Quality:

TSA maintains a set of standards called the Quality Standards Framework (QSF), against which we audit service providers through our certification body, TEC Quality Limited. This framework is designed to minimise errors. We advocate for commissioners and procurement bodies to specify the QSF in tenders. Although this scheme is voluntary, it is the only UKAS TEC accredited scheme in the sector.

The QSF is regularly reviewed to align with British and European standards, ensuring the TEC sector provides current and robust TEC services and equipment.

The Service Delivery modules of the QSF cover Assessment and Reassessment, Installation and Maintenance of TEC, TEC Monitoring, and TEC Responder Service. Additionally, there are 10 Common Standards:

- User and Carer Experience
- User and Service Safety
- Effectiveness of Service
- Information Governance
- Partnership Working and Integrated Services
- The Workforce
- Business Continuity
- Ethics
- Performance and Contract Management
- Continuous Improvement and Innovation

Our ISO 19011 trained auditors conduct on-site and virtual audits to ensure service providers have processes in place for risk assessments, re-evaluation of service user needs, and timely installation, repair, and maintenance of equipment.

Commissioners should recognise that assessing the need for TEC is an ongoing process requiring appropriate funding and service provision, which is crucial for any TEC solution.

While Livity Life (the contracted TEC provider) is QSF Certified as a monitoring centre, the frontline services provided for Hackney Council, such as TEC Assessment, Installation, Maintenance, and TEC Response, are not.

In this case, it appears there were issues with the equipment provided and the response to these failures by the commissioned TEC provider, as well as the safety and quality standards set by the commissioner in the contract for Hackney Council. We believe there are lessons to be learnt and would appreciate the opportunity to further investigate and provide comments to the Coroner, which will help prevent similar incidents in the future.

The TSA continues to advocate for the QSF to be cited by commissioners and will work tirelessly to raise awareness of the QSF's importance in ensuring the future safety of vulnerable individuals who rely on TEC equipment to remain safe and independent in their homes.

A similar initiative to that of the NHS, driven by Coroners like yourself, Directors of Adult Social Care, and the Home Office, should mandate that TEC services are verified for quality and safety through audit and endorsement of the TSA Quality Standards Framework.

I look forward to your response.

Yours faithfully,

[redacted]

Head of Quality and Improvement
TEC Quality Ltd

[redacted]

Regulation 28: Prevention of Future Deaths report

Anoush Summers (died 14.1.2024)

	THIS REPORT IS BEING SENT TO: (1) [redacted] Chief Executive London Borough Hackney Town Hall Mare Street London E8 1EA (2) [redacted] Director of Supreme Care Services Limited 9 Crown Parade Morden Surrey SM4 5DA
1	**CORONER** I am: Edwin Buckett Assistant Coroner Inner North London Poplar Coroner's Court 127 Poplar High Street London E14 0AE
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 the 22nd January 2024 Assistant Coroner Sarah Bourke began an investigation into the death of Anoush Summers who died aged 77, on the 14th January 2024 at Homerton University Hospital, Homerton Row, London, E9. The investigation concluded at the end of the inquest on 6th June 2024 conducted by myself, Assistant Coroner Edwin Buckett.

	I made a determination at inquest that the deceased died as a result of hypothermia which resulted from a fall at home following a long lie.
4	**CIRCUMSTANCES OF THE DEATH** The narrative conclusion was as follows: 1. The deceased was a frail lady who was prone to falls. She lived at home, alone, with carers who visited her twice a day. She had a wrist alarm. 2. The wrist alarm was reported as broken and not working on the 6.1.2024, but it was not repaired or replaced. 3. Sometime after 4.45pm on 11.1.2024, the deceased fell at home. She was found the next day on the 12.1.2024 at 9am, by a carer, wearing her wrist alarm and taken to hospital where she died on 14.1.2024 of hypothermia. 4. The absence of a working wrist alarm prevented her from being found sooner that she was and probably contributed to her death.
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. Evidence was given that: 1. Although the wrist alarm had been reported as broken and not working on the 6.1.2024, this was not replaced or repaired by the company engaged by the local authority to provide this service before the deceased fell at home between 11-12.1.2024. 2. At the time the deceased fell, she was wearing her wrist alarm but could not use it to summon help because it did not work.

	3. None of the carers who attended on the deceased **after** 6.1.2024 ensured that steps were taken to replace the wrist alarm or report the matter to the local authority. 4. The last carer who attended on the deceased before she died, on the 11.1.2024, was not aware that the wrist alarm did not work as she had not read the care notes. No clear instruction was given to care workers about the extent to which they would be expected to read the care notes relating to service users. 5. None of the carers had been given any training, instruction, or guidance on the testing of wrist alarms to ensure they worked properly when attending upon service users. 6. There was no clear system identified between the company providing carers and the local authority, as to the duties and responsibilities of each in the reporting of faults with wrist alarms. I rely on all the above matters. I am concerned that there is a risk of future deaths arising in circumstances when vulnerable people, who live at home and are reliant of wrist alarms which have been reported as not working, but have not yet been repaired, may unable to summon help.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and/or 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 **2nd August 2024**. 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.

	• HHJ Alexia Curran, the Chief Coroner of England & Wales • [redacted], the daughter of Anoush Summers. I am 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.
9	**DATE 6.6.2024** **SIGNED BY ASSISTANT CORONER** Edwin Buckett