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Ivor Collett
HM Assistant Coroner
South London Coroner's Office
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Date: 02/12/2025

Dear Mr Collett

Regulation 28 Report to Prevent Future Deaths: Bernard and Caroline Cleall

Thank you for the Report to Prevent Future Deaths regarding Bernard and Caroline Cleall 09 May 2025. I apologise that you have had to wait until now for a response to your report. I am putting into place measures that will avoid this happening in future.

I will address each of your matters of concern in turn.

Matter 1: The senior manager from LB Croydon Adult Social Care who gave evidence told me that he and his team were unable to access the record of the assessment carried out with Mrs Cleall at Croydon University Hospital for her discharge back to the community. I was told that the record was held by the LIFE team on an NHS system to which LB Croydon Adult Social Care did not have access.

I can understand why this evidence caused you concern. However, the evidence you received was not accurate. There was a copy of that assessment on our records. This was put on our records on 09 September 2021.

Our senior manager who gave evidence to you did so in good faith and believed the evidence he gave was accurate. My understanding is that the confusion arose as the record of the assessment was not in the section of the records where he had expected it to be.

When one of our own social workers records as assessment on our client record system, they will enter it directly on our system in a section labelled "Assessments". At the time the assessment for Mrs Cleall took place, assessments carried out on our behalf by a member of staff in another

organisation, as in this instance, would be provided to us a PDF file or a Microsoft Word document. This would then be stored in a section of our records for that person labelled “Documents”.

As our senior manager who gave evidence does not work in a part of our organisation that deals with assessments carried out by external partners, it appears that he was unaware of this arrangement.

I have enclosed a copy of the assessment completed on 09 September 2021.

Practice has since changed. Today, all assessments are now completed within the main body our client record system rather than being attached in the “Documents” section, which avoids the sort of confusion that occurred in this instance.

Matter 2: The evidence was that that what should take place at that assessment is an adequate risk assessment and a discussion with the client about which level of telecare package is appropriate. If the client declines a more expensive package against advice, this should be documented. There was no evidence in this case of the content of any assessment, discussion or advice as to the appropriate level of telecare package for Mrs Cleall.

I believe the evidence you received did not give the complete picture of what happened. We have on our records copies of the documents our Careline service completed at the time, which include a risk assessment, the agreement Mrs Cleall signed on 13 September 2021 when the service was installed, and the “Careline Plus Installation Form” which records that Mrs Cleall was told about the scope of the service and the cost of the service. I have attached copies of these documents.

I have consulted with the Team Manager for our Careline service. She wrote to me the following

> *“At the time of installation, the attending officer completed an on-site risk assessment and identified that the couple could benefit from monitored smoke alarms. However, Mr and Mrs Cleal declined this option, which we believe was primarily due to cost considerations. They noted that they already had smoke alarms upstairs and downstairs, but these were not monitored. At that time, they were on the lower rate for the alarm service (approximately £5 per week). Adding monitored smoke alarms would have increased the cost to around £12 per week, which was a significant jump. At the time of the install officers, we did not record any information regarding recommendations for monitored smoke alarms.*
>
> *Since this incident, we have reviewed and strengthened our procedures. The key changes are as follows:*
>
> *Recommendation and Recording: When an officer identifies a need for monitored smoke alarms, this recommendation is now recorded in LAS, along with the client’s decision if they decline.*
>
> - *Referral to London Fire Brigade: If monitored smoke alarms are refused, we ask for consent to make a referral to the London Fire*

Brigade and proceed with that referral. If clients refuse this is also noted on LAS.

- *Notification to ARC: We now notify the ARC if a property has smoke alarms that are not monitored. This addresses a previous issue where an operator did not recognise the sound of Mr and Mrs Cleall's smoke alarm during a call.*
- *Proactive Installation: Recently, we have acquired smoke alarms for our Chiptech units. For the past couple of months, when officers identify a need during a visit, we install these alarms as part of the basic package rather than leaving the property without any monitored alarms.*

These changes aim to improve safety and ensure that risks are mitigated effectively."

Matter 3: It appears that LB Croydon's Adult Services would also not have access to the record and the assessment when reviewing the client's situation once the package is in place and underway.

Matter 4: A review by LB Croydon Adult Social Care was due 4-6 weeks after hospital discharge but it appears that the reviewers had no access to the assessment, advice and response from the client which took place at the hospital. This would mean that the review was missing vital information which might have had a bearing on whether the telecare package should have been revised to include the enhanced service with an automatic smoke detector facility.

As noted above, there was a copy of the assessment on our records along with the documents relating to the Careline installation. These were available to anyone reviewing Mrs Cleall's situation. We carried out a review of Mrs Cleall's care and support arrangements in October 2021. I have attached a copy of this review, which at the time was carried out under our "Challenge Panel" process, where it can be seen that those that carried out that review were aware of the contents of the assessment of 09 September 2021.

Matter 5: In summary, I am concerned that the inability of LB Croydon Adult Social Care professionals to access records of an earlier assessment undertaken (and advice given) by their colleagues, together with the NHS LIFE team, deprives LB Croydon Adult Social Care of the ability to review the client's needs properly (with the necessary information) following discharge into the community.

I hope that I have been able to give you the assurance you need that we have in place arrangements that can and do allow our social care professionals to access records of earlier assessments undertaken, and advice given, by their colleagues. In addition, our Careline service identified and acted upon the learning from the sad events leading up to the deaths of Mr and Mrs Cleall, reducing the likelihood of something similar happening again.

May I again apologise that the evidence we provided at the time of the inquest was not as complete as it should have been and assure you that we will make best endeavours to avoid this happening again.

Yours sincerely

Corporate Director Adult Social Care & Health

Appendices

1. LIFE assessment 09 September 2021
2. Croydon Careline Plus information
    a. Client information sheet (2 pages)
    b. Careline Plus agreement (13 pages)
    c. Home Health and Safety Risk Assessment (2 pages)
    d. Careline Plus Installation Form (1 page)
3. “Challenge Panel” review 07 October 2021