Coroner, South London Area

South London Coroner's Office

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IN THE INQUEST TOUCHING THE DEATH OF CAROLINE CLEALL
and
IN THE INQUEST TOUCHING THE DEATH OF BERNARD CLEALL

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Director of Adult Social Care and Health, London Borough of Croydon**
1	**CORONER** I am Ivor Collett, HM Assistant Coroner, for the coroner area of South London.
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 2 February 2022 inquests were opened into the deaths of: (1) Bernard Cleall and (2) Caroline Cleall. The two inquests were heard together and concluded on 28-29 April 2025. The conclusions of the inquest were that the deaths resulted from an accidental house fire. In each case the medical cause of death was "*Inhalation of smoke*" and the short form Coroner's Conclusion as to death was "*Accident*".

4	**CIRCUMSTANCES OF THE DEATHS** The two deceased persons were a husband and wife who died together at home in a house fire in the early evening on 5 January 2022. They were aged in their seventies. The wife, Caroline Cleall, suffered from health issues including limited mobility. She was in receipt of a care package arranged by LB Croydon Adult Social Care following discharge from a hospital admission in September 2021. Before discharge from Croydon University Hospital her needs and her ability to cope in the community had been assessed by an integrated team including representatives of LB Croydon Adult Social Care and an NHS team called "Living Independently For Everyone Services", known as the LIFE Team. That assessment resulted in a care package of domiciliary visits and the provision of a telecare service managed by LB Croydon under its Careline service. The Careline service decided upon was the basic telecare package involving an alarm call button on a pendant to be worn by Mrs Cleall during the day until going to bed. In the event of a fall or other need to call for help she could press the button and it would send a call to a call operator. On the day of the deaths, Mrs Cleall operated the pendant button but was unable to communicate meaningfully with the call operator as she was stuck in the sitting room of the house where the fire had taken hold (away from the main communication device), and her husband was incapacitated by smoke / fumes. A smoke alarm was sounding in the sitting room but it was not heard by the call operator. The operator caused Careline responders to attend, but the fire brigade were called only once the responders arrived and discovered the fire. By that time it was too late to save the two occupants of the house. The firm view of the fire service is that telecare services should by default be recommended to include the enhanced package option. This includes a smoke detector which, when triggered, sends an urgent signal to the call operator without the need for the client to operate the pendant button. That automated call would result in the fire brigade being notified of an emergency immediately.
5	**<u>CORONER'S CONCERNS</u>** 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) 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. (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. (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.

	(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. (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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you / 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. 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 • [redacted] – Next of kin of both deceased persons • Doro Care (UK) Ltd, trading as Careium • London Fire Brigade 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.
9	**Signed:** **Ivor Collett, HM Assistant Coroner** **9 May 2025**