IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Derek Clifford Dudley
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • [redacted], CSS Telecare Service Manager • [redacted], Community Alarms Manager, Elmbridge Borough Council • [redacted] Community Support Manager, Tandridge District Council • [redacted] Community Services Manager, Elmbridge and Ewell Borough Council
1	**CORONER** Ms Anna Loxton, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** An investigation was commenced on 7th March 2017 and the inquest into the death of **Derek Clifford Dudley** was opened on 25th May 2017. It was resumed and concluded on 15th September 2017. I found the medical cause of death to be: 1a. Hypothermia II. Cerebral vessel atheroma and general frailty I determined that Mr Dudley had succumbed to hypothermia having fallen outside the back door of his home address and I returned a conclusion of 'Accidental Death'.

4	**CIRCUMSTANCES OF THE DEATH** Derek Dudley was found deceased from hypothermia outside the back door of his home address shortly after 1pm on the afternoon of 6th March 2017. He had been cooking himself dinner and a portion of frozen fish was found near his body, his freezer being located in an outbuilding. His last known contact was on 5th March 2017 at 2.24am when he activated his community alarm and reported that he had fallen over in his kitchen. The operator remained on the line for 10 minutes whilst Mr Dudley tried to get up, then ended the call before he was able to do so, telling him to press the alarm again if he needed help. Mr Dudley had stated he thought he could get up without an ambulance attending at the start of the call and was not asked if he would like his emergency contacts to be informed. Mr Dudley's brother, [redacted] gave evidence at the inquest that he did not believe he would have been cooking his dinner in the early hours of 5th March as this was not his routine, and therefore he believed the fall leading to his death was a separate later incident from that which caused Mr Dudley to activate his alarm. Mr Dudley had also stated he had fallen inside his kitchen but was found deceased outside. However, this was the last known contact Mr Dudley had and it is not known whether this fall contributed to his subsequent death. I accepted Mr [redacted] evidence that it would not have been Mr Dudley's routine to be cooking in the early hours of the morning and that this therefore suggested he had suffered a subsequent fall before 1pm on 6th March.
5	**CORONER'S CONCERNS** The court heard evidence that Mr Dudley's emergency contacts believed they would be telephoned automatically if Mr Dudley activated his alarm, and stated they had signed a form agreeing to be called at any time of day or night. Mr Dudley was not asked if he wanted his emergency contacts to be telephoned and [redacted] CSS Telecare Service Manager, stated they would not be contacted unless the service user requested this. Mr Dudley was only offered an ambulance once during the course of the telephone conversation and no attempt was made to persuade him to accept any help.

	The call was terminated without Mr Dudley having got up from his fall, which [redacted] confirmed was in breach of the policy of CSS Telecare Service. The operator attempted to contact Mr Dudley by telephone again 1.5 hours later, which [redacted] again stated was in breach of Telecare's policy, but there was no answer and no further action was taken. The Telecare operator who took Mr Dudley's call was in her probationary period with the Service but was able to take the call without direct supervision and did not need to seek approval before closing the call. Evidence was heard during the inquest that no pro forma questions are provided to the Telecare operators for dealing with calls and call handling guidance is provided to each operator on a USB stick which they can access via their work computer if needed. [redacted] also confirmed that whilst an extensive assessment of new service users is undertaken with their next of kin, this information is not accessible to the Telecare Operators who are provided with a very brief sentence describing the service user's requirements. The **MATTERS OF CONCERN** are: - Emergency contacts are not informed they will only be telephoned if the service user activating the alarm requests this; - Trainee Telecare Operators are allowed to take calls unsupervised during their 6 month probationary period, and do not have to seek approval before closing calls at their discretion; - There is no pro forma list of questions for Telecare Operators to ask service users following alarm activation to assist in assessing their needs and action required; - Insufficient background information is provided to the Telecare Operations to enable the service user's needs to be properly assessed, despite an extensive assessment taking place at the time of new service users signing up to the service Consideration should be given to whether any steps can be taken to address the above concerns.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. See names in paragraph 1 above 2. [redacted] 3. The Chief Coroner In addition to this report, 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: **ANNA LOXTON** **DATED this 21st day of September 2017**