for Bedfordshire & Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **First Port Retirement Property Services Limited** **Marlborough House** **Wigmore Lane** **Luton** **LU2 9EX**
1	**CORONER** I am Ian Pears, Acting Senior Coroner for Bedfordshire & Luton
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 5 July 2017 I commenced an Investigation into the death of **MAVIS JEANNE REEVES**, 83 years old. The Investigation concluded at the end of the Inquest on 31 January 2018. The Conclusion of the Inquest was 'natural causes'.
4	**CIRCUMSTANCES OF THE DEATH** On the 1st July 2017 at 08:52 hours the deceased pulled her Careline cord in her flat saying she had a dry mouth and was struggling to breathe. The Paramedics arrived in the car park at 08:55 hours but due to an automated entry system, and obtaining a key to her flat, there was a delay in their reaching the deceased. The Paramedics were with the deceased at 09:18 hours and performed CPR until 10:12 hours.
5	**CORONER'S CONCERNS** During the course of the Inquest the evidence revealed matters giving rise to

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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. –

(1) At the Inquest it was revealed that there are 4 ways a non-resident can enter the building:
   (a) By entering the room number on the keypad
   (b) By using a code
   (c) By pressing 2 buttons, namely "clear" and then "call"
   (d) By being allowed in by a resident that was passing through the entrance

   The deceased did not answer the call; the code was not available to the paramedic, who had arrived before it was forwarded to his car's computer. In any event that which arrived was probably not the correct code.

   The "call" button is supposed to connect to the Emergency Call Centre, but will not connect if the Careline has been pulled. In this case, the fact that the deceased was still talking to the Careline Operator meant that option (c) above was not available to the paramedic. This is because the system in place is an analogue system and there is only one line going from the building to Careline.

   Evidence was heard that only 3% of Careline calls result in 999 being called. The remaining 97% are non-urgent calls, accidental calls and calls by residents who are lonely.

   This means that access using option (c) could be deprived by anyone else in the building using the system.

   Further it means that once one resident is using the system that no other resident can call the Careline, even if there is an emergency.

   The scenario of a resident calling the Careline in an emergency and staying on the line is understandable and cannot be that unusual.

   It appears that a digital system would avoid these problems.

   It is understood that for a digital system to be installed the residents must agree to fund it, and that would then form part of the service charge.

   My concern is twofold. First, do the residents know of the limitation within the Careline System currently installed? Secondly, in the absence of an upgrade to digital, plans need to be put in place so that the emergency services can gain access without undue delay.

(2) The Inquest heard that the analogue system takes 90 seconds to connect. The reason for this is because it is also sending data relating to the caller to the Careline Operator's Terminal. A digital system would reduce that to 4 seconds.

My concern again is whether the residents know this. In cases where promptness is important 90 seconds can be the difference between life and death.

(3) The key safe contains numerous keys including the master key. The paramedic had difficulties identifying which was the master key.

It is important that the keys be clearly labelled to avoid delay in the emergency services gaining access.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you 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 **13 April 2018**. 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] (niece of the deceased), East of England Ambulance Service NHS Trust and to Appello Limited.

It appears to me that your residents need to be involved in deciding whether to incur the cost of an upgrade. I have attached a redacted copy of this Regulation 28 Report and I give permission, should you feel it appropriate, to send the redacted copy to your residents either in person or to each residence to be placed on a central noticeboard.

	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	**Dated 06 February 2018** **IAN PEARS** **Acting Senior Coroner** **Bedfordshire & Luton**

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