In the matter of the inquest into the death of Pauline Brumfitt

THE RESPONSE OF ANCHOR HANOVER GROUP TO THE PREVENTION OF FUTURE DEATHS REPORT DATED 6 APRIL 2021

The Anchor Hanover Group ("**we**" and "**our**") writes further to the Prevention of Future Deaths Report made by the HM Senior Coroner pursuant to Regulation 28 of the Coroners (Investigations) Regulations 2013 (**the Regulations**) dated 6 April 2021 (**the PFD Report**).

Within the PFD report, the HM Senior Coroner raises three matters of concern as follows:

(1) The policies and procedures in existence at the care home pertaining to falls risk assessment and prevention were not applied to Pauline Brumfitt as they should have been;

(2) Pauline fell on 3 occasions and the opportunities to assess Pauline's risks and take appropriate action to prevent further falls were not taken as they should have been; and

(3) The matter was not reported to the regulatory bodies, an investigation had not been commenced at the time of the inquest and staff supervision/discussion re falls prevention only commenced in February/March 2021. Appropriate timely action could have helped to prevent future deaths in similar circumstances.

Before providing our substantive response to these concerns, we would like to offer our sincere and heartfelt condolences to the family of Mrs Brumfitt.

We also wish to express our disappointment at the decision to issue a PFD Report in this case and repeat our position, as explained in our letter to the HM Senior Coroner dated 28 March 2021, that the requirements of Regulation 28(3) of the Regulations were not met. We were not afforded a proper opportunity to provide any explanation in relation to the matters of concern raised both during the inquest and within the PFD Report.

The only witness called to give evidence on our behalf was a witness of fact to the falls (despite having not been present at the time) and who was not properly qualified to explain the supervisory measures that exist, across our organisation, above home level. Had we been given the chance we could have put forward a witness to explain our procedures to the satisfaction of the HM Senior Coroner. In failing to make any such enquiry, the inquest did not have proper consideration of all relevant matters and, noting the requirements of the Chief Coroner's Guidance Number 5 (Reports to Prevent Future Deaths) did not meet the pre-conditions to the ordering of a PFD Report.

We do not dispute that there was a failing on the part of staff within the care home to follow the extensive falls management procedures in place. It appears there were a number of shortcomings within the home around falls management and we do not seek to excuse these. It has come to light as part of our investigation into relevant events that a small number of staff within the home had developed an internal culture lacking in the level of transparency that we demand and expect. This is extremely disappointing.

A deliberate failure on the part of senior management within the home to properly record and report incidents is the reason why we had commenced no investigation until March this year.

In short, we were unaware of this matter until receipt of correspondence from the HM Senior Coroner on 3 March 2021. In light of the deliberate actions of the individuals involved it is questionable as to how, even with the most intrusive level of oversight, we would have identified this.

Disciplinary proceedings have been initiated against those involved. The Home Manager was suspended pending disciplinary action and has since failed to engage with the disciplinary process. She has now resigned and a Disclosure and Barring Service (**DBS**) referral has been made. The Local Authority Safeguarding team have been notified.

Turning to the specific matters of concern raised in the PFD Report.

Falls risk - policies and procedures

We have extensive falls management policies and procedures that apply across all of our care homes. Upon admission to one of our homes, all residents are required to be assessed for falls risk and the outcome recorded in a falls risk assessment. Where deemed to be at risk of falls the resident will have a falls prevention plan (**FPP**) put in place. Staff in our homes work closely with GP services and are aware of how to refer to the local authority falls team, where necessary, to ensure that healthcare professionals actively support the home in developing the highest possible standards of FPP.

Our falls management procedures have been continually enhanced and subject to rigorous scrutiny. They include:

a) Detailed guidance through our "Personal Planners Toolkit" which explains how to develop each resident's care plan and our expectations as to how information should be recorded within it. Care plans and any risk assessments (including falls risk assessments) must be reviewed monthly by care staff as a minimum. Within the Toolkit is a clear explanation of what we require to be recorded in the mobility care plan, falls risk identification (**FRI**) and any FPP. Our FRI and FPP must be reviewed and updated every six months or following a fall. Following any fall we require 72 hour post fall observations;

b) A "falls prompt card" for holistic assessment and to include within any FPP;

c) Our homes are required to undertake an audit within 48 hours of the resident's admission which includes a review of any mobility assessment, FRI and FPP;

d) We have a "falls response flowchart" which provides a clear explanation to our staff as to how any fall within our services should be dealt with;

e) A slips, trips and falls policy (last updated in May 2020);

f) Our Call Systems and Assistive Technology policy issued in December 2020 which introduced additional guidance regarding the use of sensor mats, the importance of ensuring they are placed correctly to reduce the risk of resident falls and production of a new Assistive Technology Sensor Checks form which is completed every time sensors are used to ensure they are positioned and working correctly;

g) A detailed post-falls checklist; and

h) All of our staff go through a robust training programme which includes specific training on falls awareness.

With the exception of our “Call Systems policy” all of the above falls management measures were in place at the care home in February 2020. The HM Senior Coroner makes no criticism of the content and robust nature of these policies.

Application of falls prevention and management procedures

As a result of our investigation and the concerns identified once made aware of this inquest, we have taken a number of actions to reinforce our expectations around falls management, transparency and reporting. This has been communicated across all of our services.

Specifically in relation to the management of falls risk and falls response we have:

i) Introduced a detailed individual falls tracker through a falls monitoring workbook. This was in place at the care home in June 2020 to enhance falls analysis and person centred intervention and support;

j) Enhanced the “Event Capture” system allowing immediate access to home level data across a number of categories including falls;

k) Reinforced the falls procedures to all staff within the care home and a undertaken a robust supervision (by our District Manager) on falls management to all staff;

l) Rolled out a series of falls awareness presentations to the care home and all homes across the district to ensure that all staff within those homes have a clear understanding of our policies, better awareness around falls and how to manage them. This has been shared nationally across all of our care home services;

m) Held a series of management meetings across the relevant district, hosted by the District Manager and our client’s safeguarding team, to reinforce the importance of accurate record keeping, reporting, transparency and openness;

n) Introduced an improved falls tracker which requires a physical audit by the home manager around the home. The District Manager has undertaken a detailed audit for the care home involved in the inquest;

o) Requested the District Manager to review all falls on every home visit to reconcile recorded falls with the falls tracker and all accident and incident forms; and

p) Our District Manager is working with our Care Quality Team to produce a more simplified version of the falls flowchart which is in the process of national rollout.

Reporting and governance

As already explained above, we are of the view that the shortcomings in this case around reporting and recording were deliberate and isolated to the care home involved. They are not representative of how we operate across our organisation. Once identified, swift action was taken against those responsible.

We have always had a strong system for monitoring and overseeing the operations of all of our services but, as we are always seeking to improve, we have put in place additional supporting measures on top of those that were already there.

We have had excellent feedback from the home managers who have been piloting the new falls tracker system. This initiative has been overwhelmingly positive with the tracker being a more effective means of overseeing falls management. This is being implemented on a

national level for homes to complete on a monthly basis to ensure clearer oversight of falls across all services.

In relation to the home involved, a very robust supervision around falls management has been given to all staff regardless of job role. This supervision has been intended as a support mechanism for all staff in the home.

As far as wider governance of our services is concerned, we have many processes in place to assist with the reporting and transparency of accidents and incidents. These include:

q) Quarterly reports in respect of safeguarding incidents across all care services;

r) Safeguarding and Serious Incident Review Board;

s) Internal inspections by the internal governance and safeguarding team which also provide a rating similar to that of the CQC , the inspection record is regularly reviewed and updated, the inspection report includes a review of a number of personal plans;

t) Accident and incident process flowchart which explains where and how incidents should be reported through the Serious Untoward Incident (**SUI**) or safeguarding procedures;

u) Safeguarding – Incident alert process guidance;

v) Safeguarding Adults at Risk Policy;

w) Falls Tracker (as mentioned above). This is reviewed every month by the District Manager to check that residents with high falls risks have the appropriate documentation in their care plans and to check what action has been taken to try to reduce further falls from occurring. This is included within monthly reporting of the home, prepared by the District Manager, to record specific actions required for individual residents to ensure that their falls risk is managed;

x) Our Care Quality team review falls across the organisation on a monthly basis to identify homes and individual residents where additional support with falls prevention may be required from a specialist Care Quality Adviser;

y) Event capture system through which homes are required to electronically report any incidents or untoward events. This includes anything relating to falls and falls management. All falls data input into event capture is capable of analysis at individual, home, district, region and national level meaning all homes can be reviewed at any point to provide oversight that falls are being managed appropriately. Staff are trained on how to use and record incidents through event capture; and

z) Event capture also reports SUIs and safeguarding issues and enables each home to upload documents or enter additional notes. The data from the event capture system if fed into quarterly reports to the Safeguarding and Serious Incident Review Board.

In addition, we have also recently introduced the following:

aa) We have undertaken a review of our internal coroner process. This has resulted in the introduction of a more formal internal triage arrangement which enables our safeguarding team to monitor trends and support risk assessment;

bb) Additional handover guidance; and

cc) Improvements to our Care Quality Indicators which provide organisational oversight across all of our care homes. This includes specific incidents including deaths, falls and enables our client to address any trends or gap analysis; and monthly calls with the Directors of Care to consider risk. Specific recent changes include the service improvement team being required to provide reports of support provided, why and where by a certain date. This means that the lead for risk consideration sits with both the service improvement team and Director of Care Quality which in turn will help the Director of Care to consider services highlighted within their region.

We are confident that all of our processes and procedures around falls risk, risk management and governance are robust, suitable and continue to work well across all of our registered locations.

For and on behalf of the Anchor Hanover Group

27 May 2021