THE RED HOUSE
Care and understanding with humanity

Ms Susan Ridge HM Assistant Coroner for Surrey
Woking Coroners Court
Station Approach
Woking
GU22 7AP

29 October 2024

Dear Madam

The Inquest Touching the Death of Paul Rodney Batchelor
Regulation 28 Report – Action to Prevent Future Deaths – The Red House Care Home dated 13 September 2024 (the "Report")

We refer to the above and write to provide our response to the Regulation 28 Report to Prevent Future Deaths, received on 16 October 2024.

The covering email from the Coroner's Officer confirms that the due date for our response is 56 days from the Report, so 8 November 2024.

This response is made under paragraph 7(2) of Schedule 5 of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. We understand the response must contain detail of action taken or proposed to be taken, setting out a timetable for action. Otherwise, we must explain why no action is proposed.

We have addressed the Second Concern in the Report as below: -

> The coroner notes that the care home has taken steps to ensure that any resident in distress and calling for help at night is heard. However, though the coroner has been shown minutes of briefings to care home staff conducted after Mr Batchelor's death emphasising the need to conduct checks of residents by going into a resident's room, she remains concerned that such briefings have not been formalised into care home policy and procedures. Nor do the minutes of those briefings explain what staff should do if they are frightened or concerned about entering a room on their own. There is the risk that rather than disturb a resident care home staff through, for example, fear or lack of time do not check a resident who may be in distress.

We provide a list of actions taken and the relevant dates for each as follows: -

Action Taken	Date of Action	Date Evidence Sent to Coroner
Review of staffing levels	26/06/2023	ATTACHED 29/10/2024
Urgent Flash Reflective Debrief meeting	29/06/2023	26/01/2024
Staff meeting – flash	29/06/2023	30/08/2024

Individual supervision with DS (Carer)	29/06/2023	ATTACHED 29/10/2024
Lessons learnt session with DS (Carer)	29/06/2023	26/01/2024
Lessons learnt session with SM (RGN)	29/06/2023	26/01/2024
Lessons learnt session with DP (Carer)	29/06/2023	26/01/2024
Night allocation – reviewed	05/07/2023	In oral evidence
--monthly Bed Condition Reports instigated	Dec 2023	In oral evidence
Challenging Behaviour Support training	30/04/2024	ATTACHED 29/10/2024
Staff meeting – Flash	03/07/2024	30/08/2024
General staff meeting	09/08/2024	30/08/2024
General staff meeting	14/08/2024	ATTACHED 29/10/2024
Group supervision / lessons learnt	17/09/2024	ATTACHED 29/10/2024
Individual staff supervision – all staff	18/09/2024	ATTACHED 29/10/2024
Permanent staff Induction amended	19/09/2024	ATTACHED 29/10/2024
Agency staff Induction amended	19/09/2024	ATTACHED 29/10/2024
Bed Inspection report	19/09/2024	ATTACHED 29/10/2024
Night staff Meeting	20/09/2024	ATTACHED 29/10/2024
Staff Deployment and Retention policy updated	23/09/2024	ATTACHED 29/10/2024
Post Incident Training delivered by Legal Professionals	11/10/2024	29/10/2024
Reviewing the options for acoustic monitoring to be installed at the home	Ongoing	In oral evidence

Group supervisions, staff meeting minutes are made available to all staff and form part of the procedures of the home.

Challenging behaviour training was conducted by Elgee Training on 30 April 2024 and incorporated the following. The narrative from the trainer is as below: -

The learning outcomes were:

- *Understand what behaviour that challenges is and what person-centred values are, how to recognise triggers & report them*
- *Understand the needs of the people we support so their care is needs led*
- *How to keep you safe if a resident is violent or aggressive*
- *Produce a positive behavioural support plan*

My brief and, therefore, my narrative for the training was:
Identify challenging behaviour theory and meaning, De-escalation techniques, principles of positive behavioural support, ABC process (to identify triggers to this behaviour),

Actions to avoid being restrained or attacked, post-incident actions, record keeping, de-briefing,
Why do people challenge – often because of unmet needs (so what are they?).
These unmet needs would have become a group exercise and would have included, not enough sleep, being disturbed, hungry, cold, thirsty, lonely, uncomfortable, too hot, too much noise, you not understanding me, in pain, need the toilet etc.

Know when to walk away (this is in the handouts too), and either hand the situation on to a colleague or get some help at that stage.
Make sure incidents are recorded and the information passed on to the shift leader.
Make sure that you have not placed yourself in a vulnerable position when entering a residents' room or go in with a colleague.
Don't ignore these challenges. Record and report them otherwise they can become normalised (and then they don't get seen)

During my discussions, I would have mentioned that if we can determine what triggers the behaviour that challenges, and then avoid the triggers by changing our behaviour, then the incidents won't happen.

To record this, we use the ABC method.

The Mental Capacity Act determines that if residents have capacity, then they have the right to say no, and to live their life the way they want it, if that is possible within the confines of a care home.
Any changes would trigger a review of that resident's care plan – your care plans and appropriate risk assessments are reviewed 4 weekly or sooner.

Post incident action

The Red House has taken several steps immediately following the incident. The Manager met with care staff the following day and conducted reflective practice/lessons learnt with the staff present during the incident.
The Manager then met with all staff, who were made aware of the risks of not responding to a call for assistance from a resident and the tragic consequences that can occur. All staff received individual supervision sessions and group supervision where this incident was discussed, and measures put in place to prevent a recurrence.
Staff were instructed that if they felt unsure for any reason responding to a resident call for assistance, then they are to inform a colleague and enter in pairs, or the duty nurse. The individual supervision with DS (carer) clearly outlines what action to be taken if she felt unsure about entering a resident's room.

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The staffing levels in the home were reviewed on 26 June 2023 and a change to the allocation of night staff was made to ensure all floors had care support throughout the night.

Since the inquest concluded, we have communicated to all staff the coroner's concerns and whilst we believe this was an isolated and unforeseeable occurrence, the home has continued to reinforce the learnings to the present time, being 16 months following the incident.

A policy was in place at the time of the incident (the *Room Call Policy and Procedure*) for care staff to respond to call bells and has been extended to include if a resident was verbally calling out for assistance. The policy is that there is to be no exceptions ever to physically checking on a resident. We will keep our policies under review to ensure that any positive changes to them will be made for the benefit, health, and safety of the residents.

QR codes are now being placed in the residents' bedrooms so that staff, when completing night checks, must enter the bedroom and scan the code using the handheld PCS device to record the check on the care system.

The home had further post incident training on 11 October 2024 delivered by legal professionals versed in care matters.

The home is also investigating options for acoustic monitoring to be installed.

All staff training is maintained above 98% compliance and staff have competency assessments to ensure their knowledge and skills are current and up to date.

As stated at the hearing, the carer involved is no longer working at The Red House and I would like to assure you their actions in no way reflect the high standard of care that staff at The Red House deliver.

The staff team have been shocked and saddened by the events that led to the death of our resident PB and have embraced the changes that have been made to mitigate the risk of this happening again in the future.

Mindful of the changes that we have implemented above, and which will be continuously monitored and reviewed going forward, we believe that all our residents are appropriately monitored, they are not left unattended and the environment that they live in is safe.

We hope we have addressed and allayed the concerns of the Coroner in our response above.

Yours sincerely

[redacted]

[redacted]

Registered Manager