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Mr Oliver Longstaff
Area Coroner for West Yorkshire
His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield
WF1 2TS

By email only: [redacted]

Your Ref:

Our Ref: [redacted]
Please quote this when replying

Date: 6 January 2025

Please ask for: [redacted]
E-mail: [redacted]
Mobile: [redacted]

Dear Mr Longstaff,

Inquest into the death of Gloria Linton - Regulation 28 Report to Prevent Future Deaths – Response by Lifeway Care Limited

This response is provided to Mr Oliver Longstaff, Area Coroner for West Yorkshire on behalf of Lifeway Care Limited following the inquest into the death of Mrs Gloria Linton.

Coroner's concerns

The Coroner's concerns dated 2 December 2024 were as follows:

1. The care plan in place for Gloria required her to be transferred between sitting and standing by two carers using a piece of equipment called a Rotanda.

2. Prior to the events of 6 August 2022 it had been noted and reported that carers were not routinely using the Rotanda, and it had been reiterated to carers by the relevant Community Health Trust that the Rotanda should be used, notwithstanding Gloria's reluctance.

3. On 6 August 2022 the carers did not use the Rotanda either to support Gloria to stand so she could be dried and her skin moisturised or to assist her to sit back on the commode when her bowels opened as she was being dried.

4. Had the Rotanda been used to assist Gloria to sit, it is unlikely that she would have been placed on the commode seat at an angle such that her legs could have passed through the opening at the front of the commode seat.

5. The carers were employed by Lifeway Care Ltd.

Response - Action taken

As the Coroner is aware, immediately following the incident, all carers were provided with a refresher course in Moving and Handling, as well as refresher training on Safeguarding, Effective Communication and Reporting concerns to the Registered Manager/Office.

Since the Inquest into the death of Mrs Linton, further training has been carried out with all staff in order to ensure that carers strictly adhere to care plans with regards to prescribed equipment in the future and do not use their own discretion or judgment to determine whether or not a piece of equipment ought to be used (regardless of any desire to fulfil a service user's wishes which may involve not using prescribed equipment or any determination by the carer that it would be the safer option not use a prescribed piece of equipment).

The attached "Staff Declaration of Compliance with Care Plan and Equipment Use" document details the additional training that has been provided in this regard. It has been signed off by all staff to acknowledge their understanding and commitment to the use of prescribed equipment. Any new staff will be provided with this training.

In addition to the additional training provided to staff, Lifeway Care Limited has also arranged via its online monitoring system providers for a banner to be inserted to the top of the online app used by its carers. This means that each time a carer attends a care visit and accesses the app, they are reminded of the following message "*Attention: ensure you follow care plan and use prescribed equipment in all situations*".

As was the case prior to the Inquest into the death of Gloria Linton, Lifeway Care Limited will continue to carry out regular spot checks to ensure compliance with all its policies, including adherence to the use of prescribed equipment. It will also ensure that refresher training is provided regularly in the future.

We trust that the above action taken by Lifeway Care Limited has satisfied the Coroner's concerns but should the Coroner have any further queries, please do not hesitate to contact us.

Yours sincerely

[redacted]
Associate
DWF Law LLP