Bolton Cares
Together We Thrive

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18 February 2025

Dear HM Coroner Timothy William Brennand

Ref: Craig Brendon SPIBY (Deceased) 01844-2024

Thank you for your regulation 28 report, dated 10/12/2024. Below is our response to all the matters of concern identified in the report.

Background

Craig Spiby's death shocked Bolton Cares, in particular the support staff who had directly cared for Craig for up to 17 years. Our sincere condolences go out to Craig's family and he remains in our thoughts.

Bolton Cares is a not for profit, Local Authority Trading Company which provides adult social care services in Bolton, Salford and Wigan and has been doing so since 2016. Bolton Council is our main shareholder but we are an independent/separate entity from the Council.

High standards of quality care are of the utmost importance to us at Bolton Cares and all our staff have the right training, guidance and support available to them to carry out their roles effectively.

Internal Investigation

Immediately after Craig's death, I, as the Managing Director, initiated a full review of the circumstances that led to his death and we worked with the police and the family to understand the situation. A full review of training records, SALT guidelines, care plans and other relevant documentation was promptly undertaken by the registered manager.

The police on the scene, informed Bolton Cares that it appeared that [redacted], who was responsible for providing one-to-one support to Craig on the day of the incident, had not followed guidelines and may be interviewed under caution.

The member of staff was immediately suspended pending the police investigation.

The police later informed Bolton Cares that they were not pursuing criminal proceedings and we were able to carry out our own internal investigation.

During the investigation, we interviewed nine support staff, all of whom supported Craig regularly. This included [redacted].

We analysed training data and the guidelines that were in place and the support and supervision that the staff team had received prior to the incident.

There was evidence to suggest that the staff member had not followed guidance by a) not preparing Craig's lunch in line with the guidelines and b) leaving Craig unsupported whilst eating.

That internal investigation has now concluded and [redacted] has been dismissed.

The investigation found that Craig was at significant risk of choking and this risk was highlighted in his Support Plan and guidelines. The Support Plans are reviewed and updated regularly, and staff supporting Craig had the tools to do so effectively, including the regularly reviewed Support Plans, SALT Guidelines and 'Good day, Bad Day' guidelines. Staff supporting Craig were familiar with him and his needs and would have been considered experienced support staff. Staff supporting Craig had received recommended training, including First Aid and how to respond to a choking incident and staffing levels on the 13th July 2024 were in line with commissioned support hours.

Safeguarding Strategy Meeting

On the 10th October 2024 a Safeguarding Strategy meeting was held. The meeting was chaired by Bolton Council's Safeguarding Adults team manager to consider abuse by way of neglect/act of omission. This was in relation to the individual carer and not the wider staff team. Based on the findings of Bolton Cares' internal investigation and the findings from the strategy meeting the allegation against the carer was substantiated.

Inquest

I have now had the opportunity to consider the transcript of the inquest proceedings, Bolton Cares had been cooperating with the police investigation and understood that all relevant evidence had been provided to the coroner.

Bolton Cares was not aware that the organisation was potentially a properly interested person and could attend the inquest to assist the coroner; we understand that Bolton Council had been contacted because the coroner's court understood that Bolton Cares is part of the Council and we believe that the Council considered that we had also been contacted separately. Therefore there was a misunderstanding for which we apologise.

Had Bolton Cares been in attendance at the hearing, we would have provided additional information about the organisation, our policies on training for staff members, support planning and associated guidelines and the findings from the internal investigation including the lessons learned and subsequent changes implemented.

We deeply regret not becoming an interested party and providing all the relevant document to assist you with the inquest hearing. Our response below outlines how seriously we have taken this matter and how we have sought to address and alleviate the coroner's concerns.

Regulation 28 Report

Please find below our detailed response to each of the specific matters of concern you raise.

A lack of understanding and/or training as to the specific requirements and expectations as to the role of care staff when supervising/ monitoring a service user.

Our internal investigation found that all support staff were aware of the choking risk posed by Craig, the measures in place to reduce this risk; including how his food was prepared and how he was then monitored and supervised whilst eating; and the care plans and SALT guidelines in place for him. The staff members who we spoke to were able to relay details from the guidelines during their interviews.

All support staff, apart from [redacted], stated that they **<u>would not leave</u>** Craig unsupported whilst he was eating. The guidelines read 'supervise/monitor' and the staff interviewed understood this to be that they should physically be with Craig whilst he was eating.

We consider that the evidence taken at the inquest supports this; [redacted], Support Worker, stated "*staff won't be too far away from him, observing him".* In his statement he said that *"there's normally two members of staff in close proximity".*

[redacted], Service Manager, confirmed in his evidence that he would *"expect staff to be in eye shot of Craig".*

We believe this incident arose from one support worker, rather than staff [plural], stating that he felt it adequate to 'supervise/monitor' Craig Spiby whilst he was eating, from another room. At the time of the incident Craig was eating his lunch at the dining table and the staff member supporting him was doing so on a one-to-one basis. The member of staff left him to put away some items in another tenant's bedroom. It was during this period that Craig choked on his sandwich. This is not something Bolton Cares, or [redacted], the Service Manager, expected of [redacted].

However, since the incident, we have provided refresher training to staff, by way of a toolbox talk, to confirm what is expected when a support worker is required to be supervising or monitoring. This reinforces to staff, that they must remain in the room and remain physically present with the supported person, keeping them under observation whilst they are undertaking the task for which they require supervising or monitoring for.

The confusion that arises in the existence differing language that applies in Care Plans and Guidance with no corresponding definition of the terms used.

SALT (Speech and Language Therapy) guidelines and Eating and Drinking Guidance are provided by the Speech and Language Team from Bolton Community Learning Disability Team, Bolton Council. They do use the terms 'supervise/monitor' and these terms are then reflected in our own Provider Support Plans. Following receipt of the Coroner's report we have worked with Bolton Council and the relevant health colleagues and adult social care teams to address these issues.

Bolton NHS Foundation Trust, who employ learning disability health professionals, including Speech and Language Therapists, have provided assurance to Bolton Council Adult Services and ourselves that they have conducted an audit of various eating and drinking guidelines, including those pertaining to Mr. Spiby.

They found that whilst guidelines are comprehensive, the language used could lead to misinterpretation or lack clarity for staff and carers. To address this, a glossary of terms has been created and is being implemented across all health professional guidelines within the Community Learning Disability Team, not just those related to eating and drinking. This glossary aims to provide consistency and clarity across various guidelines.

The glossary is now included in all new guidelines produced and will be incorporated into existing guidelines during reviews, or when changes are reported. Clinical staff are collaborating with Bolton Council to distribute the glossary to other commissioned services that support individuals with guidelines, ensuring broader awareness and minimising confusion.

We have been informed that health staff will also be attending a Bolton Council organised provider forum, to allow for continued communication and co-production regarding the review of the formatting and accessibility of guidelines. This will include providers, including ourselves and those people who access services and their representatives.

If there are individual changes relating to any guidelines in place, or it is also felt within our services that there is a lack of clarity, we will be making the appropriate referrals into the Community Learning Disability Team for review.

Once these amended guidelines are in place, we will ensure that the terms of use are reflected in our support plans.

Whilst we wait for this to be undertaken by SALT professionals within the Council, we are revising our support plans (where these terms are used both within SALT guidelines and individual support plans) to include a definition of supervision and monitoring. This is also included in the toolbox talk to staff as set out above and we are proactively including this on all team meeting agendas.

How and why staff have assumed the deceased to have fallen asleep at a mealtime after a period of absence from the room, did not use more professional curiosity to evaluate whether such an assumption was correct or safe.

As indicated at the outset of this response, the conduct of the staff member supporting Craig on the day of the incident was not that expected of our support workers. Bolton Cares did not foresee that a staff member would behave in such a manner and would have expected him to check that Craig was okay. It would not have been appropriate for Craig to have been left at the table had he fallen asleep.

The other staff members who gave evidence at the inquest did not say that they would leave a service user to sleep and our internal investigation has not found that any other staff member would behave in this manner.

Given the incident, we have reflected on this and incorporated instructions to staff via the toolbox talk and their training on supervision and monitoring to include carrying out checks on unusual behaviour displayed by support users and a reminder that if support users do fall asleep, that they are checked and supported.

The lack of confidence expressed by staff in the emergency first aid training provided when responding in a choking case.

During our internal investigation into this matter, Bolton Cares considered the training provided to our workforce. All staff supporting Craig at the time of the incident had completed their mandatory First Aid training. In Bolton Cares Supported Living, we provide one day, face-to-face First Aid training which is accompanied by a face-to-face refresher training course every three years. The level of training provided is above the standards required. Online Training is considered an acceptable option, but we believe that face-to-face training is more effective and therefore provide this.

During the training provided there is a course module solely dedicated to choking and how to respond. This training is refreshed face to face every three years.

Since the incident we have provided every service that supports individuals with SALT guidelines with anti-choking devices and provided training on their use to put additional safeguards in place.

Prior to the incident, Dysphasia/Safe Swallowing training was not a mandatory requirement for support workers from *Skills for Care*. We have subsequently reviewed this and revised our policy. All staff supporting individuals with SALT guidelines now attend face-to-face Dysphasia training at Bolton Cares. This is currently being provided by our in-house trainer and SALT professionals from Salford Council. Due to the large number of staff who require this training in Bolton, our learning and development partner has approached Andrew Forbes (Speech & Language Therapist, Bolton) with a view to him providing additional training sessions in 2025.

An absence of training to guard against confirmation bias with long term service users who have enduring high risk of choking, but no actual previously recorded episodes of such events.

Craig was diagnosed with Phelan McDermid Syndrome. This syndrome increases the risk of choking and aspiration. There had been no reported episodes of choking for many years, but the risk remained consistent. To address this, we have included a reminder of not becoming complacent within the toolbox talk described above and in addition to the SALT guidelines, which we currently complete, we have implemented an electronic ‘Read and Sign’ record. This will ensure that new staff members are required to familiarise themselves immediately.

We have also included ‘SALT guidelines’ on our managers’ bi-monthly audits. This ensures that Managers are physically checking guidelines and the electronic Read and Sign sheets at every audit to gain assurance that staff members are reading them and there is a constant refresher for all staff

We have also included ‘SALT guidelines’ on our standard Team Meeting agendas. These team meetings take place every two months and by including this on the agenda we are reminding staff teams that the guidelines are in place and despite there being no incidents, the risk remains the same.

Once again, we would like to take this opportunity to thank you for highlighting the matters of concern and for giving us the opportunity to respond. We will continue to work with our colleagues in Bolton Council to ensure systems and practices continue to improve.

Yours sincerely,

[redacted]

[redacted]
Managing Director