Mr David Donald William Reid

HM Senior Coroner for Worcestershire

Worcestershire Coroner's Court

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By email to [redacted]

13 February 2025

Dear Mr Reid,

Edith Theresa PYE– Prevention of Future Deaths report

Background

We write further to your Prevention of Future Deaths report (PFD) issued on 20 December 2024 following Mrs Pye's Inquest. Your letter was addressed to [redacted] the Chief Executive Officer of Care UK, who asked me to carry out a thorough investigation before formally responding.

I am a Solicitor having qualified in 1996. I joined Care UK in October 2007 to set-up the legal function and have run it since then. One of my responsibilities is the oversight of any Coroners' Inquests that Care UK is involved with.

At Care UK we take a Prevention of Deaths report very seriously. The investigation has involved Lilly Dahms the Home Manager of Chandler Court care home; [redacted] the Regional Director who manages [redacted] [redacted] the Head of Nursing, Care and Dementia; [redacted] the Head of Health & Safety; [redacted] Head of Regulatory Governance and Rachel Harvey, the Director of Care, Quality and Governance who also manages [redacted].

We will address your concerns separately:

Concern 1

1."At the inquest, the care home manager gave evidence that the care home recognized that Mrs. Pye was a high risk of falling or rolling from her bed, and also had a history of making unsubstantiated accusations against staff. The care home therefore required:
(a) that Mrs. Pye's personal care should always be provided by no less than
two carers; and
(b) that personal care should be provided, where possible, by two female carers, and if not possible, one female carer should always be present.
These requirements should have been reflected in Mrs. Pye's care plan, but the care plan was ambiguous – for example, it stated:

"Edith may require the support of 2 carers with personal hygiene needs" and *"Edith prefers to receive care from female carers – if this is not possible with the allocated staff for the shift, assistance should be sought from another suite"*

Our response:
All care plans at Chandler Court care home are being audited to ensure that there are no ambiguous instructions in relation to residents' care needs. This review includes moving and handling, and personal care needs. Currently 20 care plans have been audited and we expect to complete the remainder by close of business tomorrow; 14 February 2025.

The Home Manager and/or Deputy Manager speak to the care team on a daily basis in order to make sure that all care plans are accurate and their team clearly understand the needs of every resident in the care home. This takes place during (i) morning meetings where all heads of department, nurses and team leaders are involved; (ii) each handover meeting and (iii) via the care home's internal online communication system.

Additionally, it is Care UK policy that care plans are audited on a monthly basis within the home. The Home Manager is responsible for reviewing and signing-off the audit. As a consequence of this Inquest we have updated the audit checklist to emphasise that the language used must be accurate. The checklist now provides this incident as a specific example, such that in the future if a care plan states that a resident may be assisted by two carers instead of must be assisted by two carers it can more easily be identified and corrected.

Concern 2
"The carer who provided personal care to Mrs. Pye on the occasion when she fell from her bed on 29.3.24 knew that he should have done so with a colleague but would regularly do so on his own. He had never himself read Mrs. Pye's care plan, and it became clear that two other members of staff who provided evidence to the inquest were also unaware of some key aspects of the care plan."

Our response:

Since the Inquest hearing, the entire care team at Chandler Court has received supervisory training highlighting the importance of reading and understanding care plans and reiterating the relevant components of the Care UK e-learning programme.

In line with Care UK policy, we will continue to review and update care plans on a monthly basis as well as when there is a change in the care needs of the residents.

Additionally, Chandler Court now involves key workers who, along with the shift leads, are responsible for having a sound knowledge of the residents' care needs and disseminating key information to their teams.

For new residents, the Home Manager or Deputy Manager notifies the entire care home of the arrival of the new resident and their key care data.

For new employees, team leaders and nurses allocate specific time during their induction programme to review residents' care plans.

Concern 3

"...other staff were aware that he would often provide care to Mrs. Pye on his own, but no-one had reported this to senior staff or taken any action to try to stop it happening..."

Our response:
All Care UK employees receive Safeguarding and Protection of Vulnerable Adults eLearning training during their induction programme. This training covers the Care UK Whistleblowing policy and ensures that colleagues understand their right and duty to raise concerns. This training must be completed within 2 weeks of their start date and refresher training is carried out every 15 months after that.

The key Whistleblowing information is summarised on posters that are displayed throughout Chandler Court, such as the nurse offices and colleagues' rooms. These posters highlight the relevant contact details both inside and outside of Care UK.

The Care UK induction booklet for new employees also covers our Whistleblowing policy and provides contact details for raising concerns.

We appreciate that colleagues did not raise concerns regarding the staff member who was providing care to Mrs. Pye in contravention of her care plan. This was not in line with our policies and the training that colleagues had received at Chandler Court.

Since this incident, there have been changes in personnel at Chandler Court, and current colleagues have been reminded of their duty to report concerns and the mechanisms available to progress any such concerns.

Additionally, individual supervision has been completed for moving and handling whereby senior members of the care team observe junior colleagues to ensure correct compliance with Care Plans and policies. Refresher training on moving and positioning has also been carried out. This training is currently at 90% compliant and is expected to be 100% compliant by close of business tomorrow; 14 February 2025. This refresher training will further assist colleagues with understanding the importance of following individual care plans and reporting bad practices, or any other concerns that may pose a risk to a resident or colleague as per Care UK policy.

Concern 4
"At the inquest, I was shown a handover document which had been drafted by the home's Deputy Manager and was told that a nurse in charge would have gone through this document with all carers at the beginning of the relevant shift. The document was meant to highlight each resident's care needs, based on their respective care plans. It did not make clear that Mrs. Pye required two carers for the provision of personal care, or that at least one of those carers should be female. There was no system in place at the time for auditing these handover documents."

Our response:

Care UK has reviewed our handover templates to ensure that they highlight the key aspects of each resident's care needs.

At Chandler Court, handover sheets are now reviewed by the Deputy Manager at the weekly clinical review meetings to ensure accuracy. In addition, any changes to a resident's care needs are reported during the daily morning meetings and the person in charge of the suite, which would either be the Team Leader and/or Registered Nurse, is directed to complete the relevant update under the supervision of either the Deputy Manager or the Home Manager.

This process ensures that the Home Manager is monitoring care plans and handover sheets are updated accordingly to reflect residents' preferences and safety needs.

Concern 5

"The Deputy Manager who had drafted this handover document, was also responsible for the care home's own internal investigation into Mrs. Pye's fall. That internal investigation failed to highlight the deficiencies in the handover document, and the handover document itself was not disclosed to the Coroner's Office until the final inquest hearing was underway."

Our response:

In September 2024 Care UK introduced a revised Safety Incident Response Framework (SIRF) policy based on the NHS Patient Safety Incident Response Framework that was also issued last year by the NHS. This policy places the responsibility to investigate serious incidents on Home Managers, so that incidents are investigated by an independent individual.

The incident involving Mrs. Pye occurred prior to the roll-out of the new policy and the training provided to support the implementation of the policy. The Deputy Manager who investigated this incident no longer works for Care UK and any future investigation will be completed by an independent Home Manager as per the SIRF policy.

The handover document was forwarded to the legal team by the Home Manager prior to the Inquest hearing. We overlooked to share it with the Court for which we apologise.

Our new investigation process (SIRF) would allow us to identify any learnings and prevent this happening again in the future.

We are confident that we have implemented a robust series of improvements which address the concerns that were raised during the Coroner's Inquest and set-out in the PFD. However, please do not hesitate to contact me should you have any queries.

Yours sincerely,

[redacted]

General Counsel and Company Secretary

[redacted]

[redacted]