Springcare (Macclesfield) Ltd

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Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths

We write in response to the Regulation 28 report which was issued in connection with the Inquest into the death of Victor Knowles, who was a resident of Henning Hall Nursing Home. This letter reflects the response of both Springcare (Macclesfield) Ltd t/a Henning Hall "the Home" and the wider group, Springcare.

The Inquest into the death of Victor Knowles was heard at Cheshire Coroner's Court on 10 to 12 December 2024. Prior to and during the course of the Inquest, the Home provided extensive evidence to assist your inquiry into the care arrangements in place for Victor Knowles whilst a resident at the Home, and the reflection which has taken place following his death to further strengthen the Home's existing procedures moving forward. We do not seek to repeat this evidence here.

A Regulation 28 Report was however issued on 2 January 2025 despite the evidence presented. This raised concerns with regard the processes implemented by the Home to investigate and learn lessons following a resident's death.

It is relevant to explain at the outset that whilst we have reflected very seriously upon the contents of your Report both within the Home and the broader service, we were disappointed that you felt it necessary to issue a Regulation 28 Report in the circumstances.

The Home has at all times had in place a comprehensive policy for undertaking internal investigations including guidance on when these are required. As you will appreciate, given the setting in which the Home operates, it would not be reasonably practicable nor proportionate to commence an investigation following all deaths or admissions to hospital. Rather, this requires the review of all incidents whereby a sudden death occurs or any unexpected hospital admission. Furthermore, a monthly review of deaths and hospital admissions considers any themes or trends. This is consistent with the protocols observed by care homes throughout the industry. We are also obliged to notify the Care Quality Commission of deaths in our home without delay under our provider and manager registration.

In respect of Victor Knowles specifically, and as explained during the course of the Inquest, he was discharged from hospital and placed at the Home for the purposes of assessment, to

identify the correct care pathway for him moving forward. Mr Knowles had been at the Home for only approximately 4 weeks at the time of his re-admission to hospital on 12 January 2024, during which time the Home had sought input from a number of professionals to support Mr Knowles' fluid and diet needs. Despite the considerable efforts made, Mr Knowles continued to decline and as such the Home arranged for him to be re-admitted to hospital on 12 January 2024 for further medical support. Mr Knowles was discharged from our care and his placement was closed. We learnt that despite medical intervention, Mr Knowles subsequently passed away on 20 January 2024.

Following Victor Knowles' death, a safeguarding report was raised by a member of the hospital dietitian team, reflecting concerns arising from their retrospective review of Mr Knowles' hospital admission notes. These concerns were carefully reviewed by the safeguarding team in person and remotely, alongside the broader care which Mr Knowles was afforded whilst a resident at the Home. The Home provided its full co-operation with the local authority's investigation, including through the provision of relevant care records. The safeguarding team subsequently concluded that the safeguarding concerns were unsubstantiated against the Home and *"That it would be unrealistic for any care home to be able to resolve Mr Knowles's long standing health and self-neglect issues."*

The review in turn identified broader learnings for the Home, which were immediately implemented.

After hearing medical evidence during the course of the Inquest, the Home revisited previous learning from earlier in the year immediately at this point to identify any further lessons to be learnt. Steps were in turn taken to implement any changes in practice, in an effort to further strengthen the systems and procedures already in place, particularly with regard to the admission of pathway for residents under the discharge to assess contract beds and the arrangements for food and fluid monitoring for residents. These steps had been considerably completed prior to the Inquest.

This review was in turn further informed following receipt of the Inquest disclosure and the provision of evidence from the attending witnesses. This was not an opportunity which the Home had been afforded (nor could have been) during its initial investigation, given the limits on the information available to it in that evidence was still being collated during the course of the Inquest. Nevertheless, this was fully reflected upon and any additional

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opportunities for learning identified. Evidence was in turn provided to you in this respect by the attending Home Manager.

Accordingly, the Home respectfully submits that the arrangements which it has in place for undertaking investigations, and identifying lessons to be learnt, are appropriate in all the circumstances, and are in line with the processes followed by the wider industry. As such, we have concluded that no further changes are required, over and above those discussed in evidence at the Inquest, to strengthen the existing arrangements in place.