FAO: HM Assistant Coroner Mr Potter
HM Coroner's Court for Inner North London

By Email Only

7th July 2025

Dear Sir,

Inquest touching the death of Mr. Ian George Stanton Simpson
Magnolia Court (the 'Home')

I write further to the Inquest of Mr. Simpson and the Prevention of Future Death Report issued on 12th May 2025 and sent to Barchester Healthcare on 13th May 2025.

Barchester Healthcare has carefully considered the issues identified at the hearing and as detailed in the Findings and Conclusion ruling received on 30th April 2025. It was deemed necessary to investigate the circumstances surrounding Mr Simpson's deterioration on 16th December 2025 and steps taken in response by the staff on duty further.

We set out the steps taken following the Inquest and the findings of our investigation below. We confirm we have updated the Care Quality Commission ('CQC') and will share a copy of this letter with them.

Findings

We have now spoken with all relevant staff working on the shift on 16th December 2024.

We confirm Barchester has found:

- it is highly likely the deterioration occurred after 09:45am on 16th December 2024.
- the entry made in Mr Simpson's records at 09:46 in relation to repositioning is likely to have been made in error and most likely relates to another resident as this care intervention did not take place with Mr Simpson.
- it is not clear where the time of 09:30am as the time of the incident originates. Whilst this is recorded in the Accident and Incident Form, no member of staff suggested that there were any concerns at this time in respect of Mr Simpson's health and wellbeing.

• Despite the evidence given, no other member of the Nursing team considered that 49 minutes is an appropriate length of time to escalate concerns to 999 if a resident is found unresponsive and staff did not recall there being any significant delay in doing so in Mr Simpson's case.

Steps taken after the Inquest

Following the Inquest, we considered it necessary to ensure staff were clear as to the organisation's expectations in relation to deteriorating residents. We acknowledged there was a need to improve staff understanding and use of EnabLE, the electronic record keeping. It was also apparent greater care was needed in the completion of Accident and Incident Forms which of course represent valuable sources of key information, if accurate. We have taken appropriate action in relation to staff members where departure from the organisation's policy was identified on investigation.

New General Manager

We have appointed an experienced General Manager for the Home who has been leading on supporting the necessary improvements and staff development.

Introduction of EnabLE

EnabLE was introduced in December 2024. Our objectives were to standardise recording, increase visibility of day-to-day care interactions at management level, improve our ability to audit and conduct trend analysis of incidents and staff performance. We are confident the introduction of this digital care support planning system will allow the organisation to continually improve the standard of record keeping and delivery of prompt and effective care. Now our care staff, as distinct from nursing staff, have handheld devices and are expected to record narratives at the point of care which represents a completely new way of working for them having previously completed minimal resident records on paper.

Implementation of EnabLE represented a significant project for the organisation. Training and coaching were provided by an implementation team to our staff before, during and after introduction
of the system. We are aware that there was a period in which staff were familiarising themselves with the use of the handheld devices and completion of prompts scheduled against resident care plans to ensure care interventions are in a timely manner, use of free text and drop-down options.

Following the Inquest, we have provided refresher training at the Home in relation to the functionality of the system, the organisation's expectations and policy in relation to record keeping and the importance of accurate and contemporaneous recording.

We have the ability to review the documentation completed by staff at the Home remotely; the Regional Director and Regional Clinical Development Nurse continue to consider the quality of entries as part of the ongoing assurance audit programme. We are currently working on setting up a trial of an integrated digital accident and incident recording system, this will be linked to the digital care planning system to allow for the capture of key information relating to the incident in real time which will support our investigation of incidents in future.

Barchester Healthcare Policy in relation to Deteriorating Residents

We confirm the following steps have been taken at the Home to ensure that staff are clear as to our expectations in relation to residents who appear to be unwell:

•I presented learning from this matter to all our home managers during our 'Leading the way' internal communication webinar on 19th May 2025. This session covered responsibility to escalate any concerns in relation to residents' health and welfare and utilise the guidance provided in our Deteriorating Resident's Policy and that 999 must be immediately called for an unresponsive resident where this represents a new presentation.

•Themed supervisions have been completed with the support of Divisional Clinical Lead Nurse, the Clinical Development Nurse and both the Regional Director and General Manager of the Home. These themed supervisions cover two main areas:

•RESTORE2 – which includes 'clinical judgement' (RESTORE2 is a physical deterioration and escalation tool for care/nursing homes based on nationally recognized methodologies including early recognition (Soft Signs), the national early warning score (NEWS2).

•Managing Resident Deterioration.

The themed supervision programme was completed by the end of June and ongoing learning and development is planned for the Home.

•Staff in the Home have also been provided with Barchester 'Clinical Shots' guidance, to inform their assessment of residents and the steps to be taken in response.

As above, the Regional Director is monitoring the care provided at the Home to ensure the learning has been embedded. The Regional Director will continue to review resident incidents during their monthly visits to the Home.

We have taken the opportunity following our investigation to review the Appropriate Admission Policy to ensure that careful consideration is given to residents with more complex needs. At the Quality First Conference in September, which will be attended by all General Managers, I will be delivering a workshop on appropriate admissions which will encompass learning from a number of cases including this one.

We take all concerns raised extremely seriously and wish to reiterate that the health, safety and wellbeing of our residents is of paramount concern. We hope this explanation offers reassurance that the risks of recurrence of issues identified on investigation have been mitigated in so far as possible.

We offer our condolences to Mr Simpson's family and friends for their loss.

Yours faithfully

[redacted]

[redacted] | Director of Nursing | Barchester Healthcare
[redacted] | www.barchester.com