

**IN THE MAJESTY'S CORONERS' COURT S.WALES CENTRAL
CORONER AREA**

BEFORE SENIOR CORONER MR GRAEME HUGHES

SITTING IN PONTYPRIDD CORONERS' COURT

**TOUCHING UPON THE DEATH OF
VALERIE HILL**

SECOND WITNESS STATEMENT OF [REDACTED]

AGE OF WITNESS : OVER 18

OCCUPATION : PRINCIPAL MANAGER FOR ADULT SERVICE PROVISION

This Statement consisting of 6 pages each signed by me is true to the best of my knowledge and belief and I make it knowing that, if it is tendered in evidence, I shall be liable to prosecution if I have wilfully stated in it anything which I know to be false or do not believe to be true.

[REDACTED]

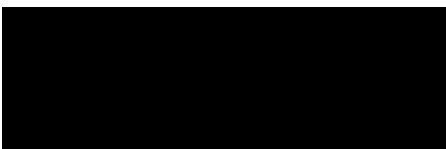
Dated: 03/09/2025

I [REDACTED] of Merthyr Tydfil County Borough Council, County Hall,
Merthyr Tydfil County Borough Council, County Hall, Merthyr Tydfil

WILL STATE :-

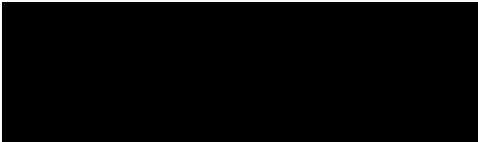
1. I am employed by Merthyr Tydfil County Borough Council ("Merthyr Council") as a Principal Manager for Adult Services. I refer to my earlier witness statement in this matter dated 23 May 2025. This is my second witness statement in this matter, and it relates to HM Senior Coroner's Regulation 28 Prevention of Future Deaths Report ("PFD Report") issued in regard to this inquest dated 13 June 2025, received by the solicitors instructed on behalf of Merthyr Council on 17 June 2025.

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2. I have received a copy of HM Coroner's PFD Report, and I have considered the same and the concerns raised in some detail. As will be seen from the later paragraphs of this statement, a number of steps have been taken by Merthyr Council to specifically address HM Senior Coroner's concerns, it is due to the complexity of some of those steps that this response was not capable of being provided within the initial timeframe provided by HM Senior Coroner.
 3. Dealing, firstly, with HM Senior Coroner's concerns as to assessment of falls risk (paragraphs (1) – (5) of the PFD Report), the concerns expressed by HM Senior Coroner, in summary, are to the effect that Merthyr Council had not applied its mind to the management of falls risk in the context of care home residents, as distinct from steps to be taken to deal with falls, the same having taken place.
 4. As addressed in my first statement, Merthyr Council relied upon the All Wales NHS Manual Handling Passport Scheme (the "All Wales NHS Scheme") and the documentation and training within that scheme. This scheme is utilised, based on this form, I understand, by the 22 unitary local authorities in Wales.
 5. Consequent upon the concerns of HM Senior Coroner, however, a number of new documents have now been drafted and have recently been implemented by Merthyr Council in the context of addressing these concerns, moving forwards.
 6. Firstly, an 8 page detailed guidance document for staff on the Prevention and Management of Falls has been developed. As above, one of the issues (if not the central issue identified by HM Senior Coroner in paragraphs (1) – (5) of his PFD Report) was the perceived lack of a distinct Falls Prevention Strategy or Policy. The Council, through myself, has taken on board HM Senior Coroner's comments and, as above, has now developed this guidance for staff directed, as far as reasonably practicable, to the prevention and management of falls in a residential care home setting.



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7. A copy of the latest version of this Prevention and Management of Falls guidance document for staff is attached to this witness statement marked “**KL 6**”.
 8. As part of the implementation of this new guidance, the Council, through myself, and in consultation with the Council’s Health and Safety Department, has also developed a new (9 page) Multifactorial Falls Risk Assessment document to be used regarding relevant users of adult services. A copy of this Multifactorial Falls Risk Assessment document is attached to this witness statement marked “**KL 7**”.
 9. Additionally, a Post Fall Summary document has also been developed as a means of review and evaluation of any falls sustained by care home residents, to further understand and review risk in general on an ongoing basis. A copy of this document is attached to this witness statement marked “**KL 8**”.
 10. Further, and again in response to HM Senior Coroner’s concerns in his PFD Report, the Council has revisited the issue of moving and handling plans for residential care home occupants. The council has now amended its approach to such plans, such that they can now only be completed by appropriate senior members of staff (care home managers, care home assistant managers and senior carers). Once completed – in any event – these moving and handling plans now must be reviewed and signed off by the care home manager or assistant manager. Staff undertaking this process will receive specific training (see below) – this is in addition to the training I identified in my first witness statement herein.
 11. As part of this process, a new Moving and Handling Risk Assessment Form has also been developed and a copy of that new form is attached to this witness statement as “**KL 9**”. It is anticipated that this new approach to the moving and handling plan will ensure that this document is a “living document” – that is to say – it is continually informed and reviewed by

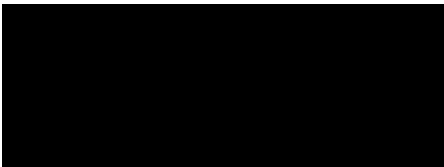


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reference to the Falls Prevention and Management Guidance, by means of update by documents including the Post Fall Summary and Multifactorial Falls Assessment.

12. Training as to the completion of the Moving and Handling Risk Assessment(s) has been provided to Care Home and Adult Services Managers by the Council's dedicated adult services manual handling trainer. Further training as to this was provided to Senior Carers and Assistant Managers. Once the Council's Trainer is satisfied that all these staff are to be regarded as competent to carry out such reviews and the drafting of moving and handling plans, they will be permitted to do so, but not before this point in time. This is something of an ongoing process, but it is designed, rather obviously, to address HM Coroner's concerns and will seek to do so.
13. There will be additional training as to the newly created Prevention and Management of Falls Guidance, the Multifactorial Falls Assessment document and the Post Fall Summary document. Once again, this is an ongoing process, but there is a meeting arranged on Friday 5th September with the Council's Health and Safety officer and Manual Handling trainer to discuss the development of this training programme.
14. Feedback on this new suite of documents has been sought from Care Inspectorate Wales (CIW) who are the relevant Regulator for Care Homes in Wales, and this has been positive. However, the documents were only finalised at the end of July 2025 and therefore it will be necessary to further interact with CIW as to the same, during the process of further inspections of care homes, following their implementation.
15. It would be fair to say that Merthyr Council has fully taken on board HM Coroner's concerns around policy documents and developed – from the ground up – suitable guidance documents addressing HM Senior Coroner's Concerns. Lying behind those additional policy documents is (see above) further training to implement these new systems. In that sense, therefore, this



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[REDACTED]

remains something of an ongoing process but hopefully HM Senior Coroner will see the progress and efforts which have been made to address the risks he has identified.

16. There were 2 further elements to the PFD Report from HM Coroner.

17. Firstly, at paragraph (4) HM Senior Coroner identified that the risk assessment forms – according to the All Wales NHS Scheme documentation provided in my initial statement – required to be signed off by a Registered Healthcare Professional. It will be understood by HM Coroner that this documentation was developed, primarily, by the NHS in Wales for use in NHS settings, with regard to the moving and handling of NHS patients. The availability of Registered Healthcare Professionals in those settings is obvious. In a local authority residential care home environment, registered medical healthcare professionals of this type are never routinely available and the “requirement” for sign off of risk assessments by such persons is actually a vestige from the original environment in which these documents were developed (see above).

18. However, to address the underlying concern by HM Coroner, presumably, as to review and counter-signature of relevant documents – this is why Merthyr Council (see above) has introduced the aforementioned process of a counter-signature on relevant manual handling plans by a care home manager or assistant manager.

19. Secondly, HM Senior Coroner wished to receive some further clarity as to what actions Merthyr Council’s Health and Safety Department take in regard to falls notifications. This is referenced at paragraph (6) of his PFD Report.

20. I have discussed this with [REDACTED] the Health and Safety Manager of Merthyr Council.

21. [REDACTED] advises me that when a report of a fall in a residential care home is provided to the Health and Safety Department – as it would routinely be

[REDACTED]

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[REDACTED]

when a care home resident sustained a fall in the care home setting (such reports being copied to the Health and Safety Department) – the report is reviewed by one of the health and safety team who would be specifically looking for any “environmental” features which may require further investigation. That is to say – they would be examining the report specifically to identify if there is any suggestion contained therein, that any issue within the care home environment was possibly contributory to the incident – so – for instance – they would look for example for any references to floor defects or carpet defects in the context of the fall.

22. On the assumption that such an issue was identified within the reporting documentation – the health and safety team would contact the care home, which may include a visit to the care home in question to further investigate and, if necessary, make recommendations. Those recommendations would be reported into the care home manager, and I would also be notified of the situation.
23. The health and safety team would also be looking for any trends in regard to falls or concerns relating to that aspect – which – if they arose – would be reported back to the Adult Social Care Management Team – likely via myself.
24. The (ever present) falls risk associated with elderly persons in a care home setting is primarily the focus of Adult Social Care and needs to be addressed via individual care plans (through Social Services) and moving and handling plans (developed on site – see above), based on appropriate risk assessments. The health and safety team’s principal involvement should be to ensure that if there is an underlying environmental or other particular risk, it is picked up and addressed. Despite the best staff and care, there will be falls from time to time – this is a recognised feature of the care of older and frail persons.