Riversdale Care Home
14-16 Riversdale Road, West Kirby,
Wirral
CH48 4EZ
0151 625 2480

Gerard Majella Courthouse
Boundary Street
Liverpool
L5 2QD

16th December 2025

Dear Sir Coroner,

Inquest touching the death of Gloria Simon Response to the Coroner

Thank you for your comments and request at the conclusion of the inquest into the very sad death of Gloria Simon. This letter sets out the response to your comments and your request as directed to The We Care Group (the Group). I anticipate that you will share a copy of this response with the family of Gloria Simon, and I would like to express my condolences for their loss.

Please be assured that the safety of those in our care is our absolute priority. During the inquest on 29th October 2025, you heard evidence from the Home Manager and Regional Manager about the initiatives and measures undertaken at the Home following the death of Gloria Simon. A Statement from the Home was also shared, detailing observation in the last 72 hours of Gloria Simon's life and the recollection of the conversation with the GP. This was requested on 24th October 2025 prior to the hearing on 29th October 2025.

We are now writing to give you assurance that further steps have been taken and actions have been implemented to address matters of concern. These have been incorporated into the ongoing provision of care services at Riversdale Care Home and have been shared more widely across our business as part of our approach to learning and continuous quality improvement.
As per your summary of concern in the prevention of future death order you stated that you remained concerned regards the following, which we have documented against each point what we have done to improve care outcomes:

1. The email sent to the GP practice with the 'Request for Care' form noted the sender's email address to be 'CARE.VLNJK (RIVERSDALE NURSING HOME, WIRRAL)'. On the form itself, the box in which the sender was asked to identify the staff involved in the case was completed with the words 'Riversdale Nursing Home', which was its name before it changed from a nursing home to a care home in 2023.

   The GP to whom the request was passed for action told the court that he believed that the Gloria Simon was resident in a nursing home setting, and that he would have acted differently (by making a visit to see her in person) if he had known that it was in fact a care home setting, with no clinically qualified staff members on site.

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The court is concerned that this preventable misunderstanding contributed to a vulnerable elderly resident being left without a face-to-face clinical assessment (which would have been likely to result in a different approach to care and management) and would like to know what measures are being taken to address this.

1. *The standard template "Request for Care Form" which is provided by the GP Surgery has now been revised. Where the form previously stated name of care home, this now has an option to circle residential or nursing. This new process led by the GP practice is proving very helpful to the team at Riversdale Care home.*

   The NHS Email used by the home has been reviewed and amended and no longer states Riversdale Nursing Home.

   Riversdale has not been registered as a Nursing home since 10th March 2023 it saddens us deeply that the GP practice who has supported the care home for many years was not aware of this. With this in mind we have sent correspondence to all external professionals who support the home to inform them that Riverdale is a residential care home and does not have nurses on site.

2. On 17 September 2025 the staff at the care home were sufficiently concerned about Gloria Simon's health that they sought assistance from her registered GP, who declined to visit because she was no longer within their area. Whilst efforts were made to register her with a practice local to the care home, staff did not make any alternative arrangements for obtaining clinical input in the meantime. The court heard that staff should have called 111. Depending upon the seriousness of their concerns, another possibility would have been to call 999. In fact, no further attempt was made to seek help until 14:52 on 19 September 2025.

   The court is concerned that the training of non-clinical staff was insufficient to equip them with knowledge about how to manage a situation such as this effectively and would like to know what measures are being taken to address this.

   Supervision of all senior care assistants has been completed by the Registered Manager which includes instruction that when a resident is unwell and a GP cannot be accessed every attempt to obtain clinical support will be made. This would include contacting 111 or in fact 999 following observations.

   Companies' policy has been revised and all new residents who are out of district with their own GP will have arrangements made within the first 24 hours to be registered with a local GP. This process is in place for both respite and permanent placement. Due to registration taking 48 hours, if a resident becomes unwell then team are to source advice from 111.

   In addition, a new audit has been developed on the company's digital systems which is completed 48 hours after any resident is admitted and includes GP registration.

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3. It was not clear from the evidence that the staff at the care home have been trained so that they have a sufficient understanding of when basic observations should be taken, how and where the results should be recorded or how they should be acted upon.

   There was no evidence that observations has been carried out prior to 19 September, despite Gloria Simon having been judged sufficiently unwell on 17 September that a GP should be called. The court was not made aware of when the observation results contained in the Request for Care form had been taken, nor whether further observations were taken at all in the period of more than 24 hours between then and her death.

   The court is concerned that the training received by care home staff did not enable them to understand the potential value and importance of basic observations, nor to understand how they should act upon them, thereby denying them (and clinicians who might be involved later) information which might assist in determining the seriousness and evolving nature of the condition of an elderly and vulnerable resident. The court would like to know what measures are being taken to address this

   Our company competency assessment has been reviewed in line with roles and responsibilities of a Senior Care Assistant.

   All Senior Care teams have undergone a competency assessment in how to complete basic observations for residents by a member of the Quality Team, this has been logged on our company learning platform.

   When observations are entered into our digital care planning system, a follow up is auto generated based on spiked observations being entered. This will support the Senior Care Assistants who are not clinically trained to interpret these results. This function has been trained for all Senior Care Assistants as part of the revised competency assessment.

Thank you for bringing your concerns to our attention. I hope that the detailed information provided in this response offers you assurance about both our systems and processes and the significant and continuing improvements we have made and will continue to make in order to mitigate risk to our residents.

We are sincerely sorry for the shortcomings in the care of Gloria Simon and are committed to ensuring that the improvements we have made are sustained both at Riversdale Care Home and across our wider business.

Yours sincerely

[redacted]

Operations Manager