THE CARE BUREAU

29 May 2026

Mr Hassan Shah
Assistant Coroner for Northamptonshire
Northampton Coroner's Court
The Guildhall
St Giles' Square
Northampton, NN1 1DE

Dear Mr Shah

Prevention of Future Deaths Report – Mr John Hay
Response to Regulation 28 Report dated 31 March 2026

Thank you for your Regulation 28 Report dated 31 March 2026 following the inquest into the death of Mr John Hay, which concluded on 31 March 2026.

I attended the inquest on behalf of The Care Bureau Limited ("TCB") together with [redacted] (Regional Manager) and [redacted] (Registered Manager). We are grateful to the Coroner for the thorough and careful conduct of the inquest and we again extend our sincere condolences to the Hay family.

This letter sets out TCB's response to each of the three matters of concern identified in section 5 of your report. We note that this response will be shared with [redacted]. We address the question of publication at the end of this letter.

Background

TCB is a domiciliary care provider registered with the Care Quality Commission ("CQC"). The business began in 1997 as a nursing agency and became a domiciliary care provider to Warwickshire County Council in 2000. TCB entered the Northamptonshire domiciliary care market in 2005. We are currently contracted as a domiciliary care provider to both North and West Northamptonshire County Councils and were a provider to the predecessor Northamptonshire County Council. In addition to our work across the West Midlands, we also have domiciliary care services in Telford and Torquay. Today, our 290 field staff provide care to approximately 600 service users on a weekly basis. TCB provides reablement care, domiciliary care and supports services users with more complex needs including overnight support.

We were commissioned by West Northamptonshire Council ("WNC") under their 2023 Framework Agreement for the Provision of Homecare Services (the "WNC Framework") to provide reablement support to Mr John Hay ("JH") following his discharge from Northampton General Hospital in September 2024. We carried out an in-person assessment and produced a Care Plan. We first provided care on 17 September 2024. JH was last in our care on 26 September 2024.

The Coroner concluded that JH died as a result of an unwitnessed fall and noted that, in the opinion of the Consultant Emergency Physician, it is unlikely that JH would have survived his injuries even if he had presented at hospital 12 hours earlier. We acknowledge that this does not diminish the importance of the concerns raised in your report, which we take very seriously.

Since the Coroner's Regulation 28 Report, we have been in communication with CQC as our regulator. We provided a detailed account of the events of 26 September 2024, together with supporting documentation, to CQC in a letter on 1 May 2026. For the avoidance of doubt, our response to the Regulation 28 Report is consistent with that letter.

Concern 1: Risk Assessment

The Coroner's concern:

"The Risk Assessment in the Care Plan is neither completed nor reviewed with nursing or medical input, but includes, amongst other things, actions to be taken when a person is on blood thinners. In the present case, the only scenario covered was in relation to a person who has "heavy bleeding". The obligation to complete the risk assessment and determine actions falls upon the care team, none of whom have any medical training, aside from basic first aid."

TCB's response:

It is important to clarify that "[the] obligation to complete the risk assessment" did not fall on the care team. The risk assessment formed part of JH's documented Care Plan. JH's Care Plan was completed by experienced supervisors and was based on the commissioning documentation provided by WNC and an in-person assessment of JH. It is correct that the care team must determine actions based on the Care Plan and the actual circumstances of delivering care.

TCB's Care Plan for JH correctly identified the risk of falls and included clear guidance that "[if] Client falls then carers must dial 999." It also separately identified the risk of anticoagulant medication and included guidance on what to do in the event of heavy bleeding. As the Coroner rightly identifies, the two risks were not linked: the anticoagulant section did not address the heightened risk that a fall poses for a person on blood thinners, where internal bleeding may not be immediately visible. Equally the fall section did not highlight the heightened risk from anticoagulants.

On further reflection and analysis we also identified that our standard falls risk did not distinguish between unwitnessed and witnessed falls.

On the question of medical or nursing input: TCB is a homecare provider regulated by the CQC. JH's care was delivered by our Northampton service, which is only authorised to provide personal care. TCB does not provide medical or nursing services and we do not represent ourselves as doing so. Like all providers of this type, our staff are not medically trained, and it is not our role to provide medical or nursing assessments. Our risk assessments are based on information provided by the commissioning authority, the service user themselves, next of kin and other relevant persons. In this case, our assessment correctly recorded JH's medical conditions – including his anticoagulant medication, his heart condition, and his dementia diagnosis – and these were reflected in the risk

management plan. We work alongside health professionals and other agencies; we do not replace them.

That said, we accept that our risk assessments should do more to link related risks and set out clearer escalation guidance.

Actions:

We have taken the following actions:

1. Updated Anticoagulant Risk: we have updated our standard anticoagulant risk assessment across all our services. The updated version now explicitly lists a fall or any blow to the head as a trigger requiring carers to call 999 and to inform emergency services that the service user is on anticoagulant medication.
2. Updated Falls Risk: we have updated our standard falls risk across all our services. The updated version distinguishes between witnessed falls (requiring a 999 call) and unwitnessed falls (requiring a 111 call), and in both cases requires carers to check whether the service user is on anticoagulant medication and to inform the relevant emergency service.
3. Review of Relevant Service Users: we have reviewed the Care Plans and Carer App notes for all service users who use anticoagulants to ensure that the Anticoagulant Risk is appropriately highlighted.
4. Systems Update: our system uses competency codes to help match carers with appropriate experience to service users. We modified the "Anticoagulant" code to further optimise matching.

Timetable:

The above actions are complete.

<u>Concern 2: Decision-Making, Personal Autonomy and Escalation</u>

The Coroner's concern:

"The process/system for escalation to get medical input was unclear. In the current case, it was accepted with the benefit of hindsight that when a frail elderly person on blood thinners suffers a fall, a medical assessment should probably be done. However, after the morning visit, it was Mr Hay himself who made the decision (despite having suffered a fall and having a diagnosis of dementia) without input from his family. At the time of the evening visit, the care team contacted the son for a decision rather than simply assessing the situation and making a decision."

TCB's response:

The Coroner's concern raises a genuine and important question about the balance between respecting the wishes of a service user (in this case with a dementia diagnosis) and following a Care Plan.

Person centred care and the promotion of personal autonomy are at the heart of the regulatory framework for domiciliary care providers. Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 ('Person-centred care') requires that care and treatment must meet the needs and preferences of the service user, and Regulation 11 adds that "[care] and treatment of service users must only be provided with the consent of the relevant person" provided they have capacity.

The CQC's own standards, and the commissioning framework under which WNC engages providers such as TCB, require providers to respect the wishes of service users. Regulation 11 is mirrored in the Service Specification of the WNC Framework, which requires that "[all] safeguarding activity must be informed by… Empowerment - People being supported and encouraged to make their own decisions and informed consent".

It is well understood across the sector that carers cannot, and should not, force a service user to accept personal care, take medication or agree to emergency assistance if they have capacity and decline.

JH's dementia diagnosis was clearly recorded in the Care Plan, both in the Medical History section and in a dedicated Mental Ability section. The Care Plan recorded that, at the time of assessment, JH's condition did not affect his ability to understand what was being communicated to him or to answer questions, and that he retained the ability to make informed decisions and choices. Prior to his hospitalisation in August 2024 JH had been living independently, managing his own daily routine and finances (with family support). Following his recovery, the hospital and WNC were satisfied that he could be discharged home with continuing support from his family and reablement support from TCB.

The WNC Framework is clear that "[capacity] is time and decision-specific, and an individual is assumed to have capacity unless, on the balance of probabilities, it is established otherwise."

Our carers are trained to look out for and escalate signs of changes in capacity, but TCB had only been providing care to JH for nine days at the time of the events in question. Our carers had limited opportunity to build familiarity with JH.

At the morning call on 26 September 2024 JH reported a prior unwitnessed fall to the carer. The carer sought to follow the Care Plan and offered to call 999 but deferred to JH. The carer respected JH's assumed capacity and autonomy. At the tea call, JH was found on the floor. In this instance the carer contacted the office who contacted JH's son.

We acknowledge that the handling of the two incidents was inconsistent and with the benefit of hindsight medical input from either the 111 or 999 services would have been appropriate.

On further reflection and analysis, we also identified that while appropriate to notify and involve JH's son, neither our Assessment nor Care Plan clearly recorded whether either or both of JH's sons

held relevant powers of attorney. This information could be relevant in similar situations where capacity is more in issue.

Actions:

In addition to actions 1-4 above, we are taking the following actions:

5. Emergency Action Plan: we are updating our Care Plans to include a clear Emergency Action Plan which will signpost to service users and their families the actions carers will take in certain circumstances. To ensure we continue to deliver person-centred care, this before-the-fact clarity is important. It has always been TCB's policy that input from emergency must be sought in the case of falls, but it is clear that this was inconsistently applied in JH's case. Our new falls risk (see above) makes it clear that advice from either 111 (unwitnessed falls) or 999 (witnessed falls) must be sought. Service users (with capacity) and their family (where relevant) can then factor that advice into their own decision making. We have implemented this for new Care Plans in May 2026 and will add this to existing Care Plans as they are periodically reviewed.
6. Powers of Attorney: we have reviewed and updated our assessment documentation to include questions regarding both health and financial lasting powers of attorney. We will be implementing this for new Assessments in June 2026 and will also check power of attorney details in existing Care Plans as they are periodically reviewed.
7. Training: we have reviewed our Manual Handling training module with our external trainers and confirmed that it does already and appropriately cover actions in the event of falls.
8. Lessons Learned: JH's case will be presented as a lessons learned case study to all Registered Managers at our next Registered Managers' meeting, with a specific focus on the tension between person-centred care and escalation obligations. The Registered Managers will then share the case study with both care and office staff in their respective branches.

Timetable:

- The training review is complete.
- The Emergency Action Plan has been implemented for new Assessments. Existing Care plans will be updated as they are periodically reviewed in the normal course of operations. For the avoidance of doubt, existing Care Plans for service users with anticoagulant risk have already been reviewed and updated as necessary.
- The Power of Attorney questions will be implemented for new Assessments in June 2026. Existing Care plans will be updated as they are periodically reviewed in the normal course of operations.
- The Lesson Learned case study will be presented at the Registered Managers' meeting in June 2026.

Concern 3: Medication Management

The Coroner's concern:

"The process/system by which missing or spent medication is actioned was unclear. In the current case, Mr Hay's son was responsible for ordering medication. However, the system by which the care team would notify him was unclear."

TCB's response:

The responsibility for ordering and collecting JH's medication was recorded in the Care Plan's Medication Plan. JH's son is documented as the person responsible for ordering and collecting medication. JH's pharmacy details were also recorded.

Our carers are trained and do know what action to take when medication is insufficient. We acknowledge, however, that our Care Plan did not include a sufficiently clear written protocol for what carers should do when medication was found to be unavailable, and specifically did not make it clear that carers should notify the office and the responsible person in a timely manner when medication was running low.

Actions:

We are taking the following actions:

9. Reminder to Field Staff: a written reminder has been sent to all field care staff requiring them to request additional medication at least seven days before a service user's supply runs out and to notify the office if medication is unavailable or running low at any visit.
10. Written Protocol: we are updating our Care Plans to include a specific and clearly worded protocol for insufficient medication. This will make explicit the obligation to notify both the office and the responsible person (whether the service user, a family member, or another party) when medication is low or unavailable, together with a clear escalation path if medication runs out. We have implemented this for new Care Plans in May 2026 and will add this to existing Care Plans as they are periodically reviewed.

Timetable:

- The reminder to field staff has been actioned.
- The written protocol for insufficient medication has been implemented for new Care Plans. Existing Care plans will be updated as they are periodically reviewed in the normal course of operations.

Representation Regarding Publication

Pursuant to section 8 of your report, we respectfully request that this response is not published, whether in full, in redacted form, or in summary. Our reasons are as follows:

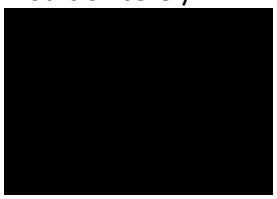
- This response has been prepared in a spirit of openness and constructive engagement. Publication would not add to the public interest in this matter beyond what is already captured in the Coroner's report itself.
- TCB is a small domiciliary care provider and publication could have a disproportionate adverse impact on the business and, indirectly, on the service users who depend on our care.
- The actions described in this response are either already complete or are being implemented. Publication is not necessary to ensure accountability.

We would be grateful if you and the Chief Coroner would have regard to these representations when considering publication.

We believe that the actions described in this response directly address each of the three matters of concern raised in your report and will materially reduce the risk of a similar incident occurring. We are committed to completing the outstanding actions.

Please do not hesitate to contact me if you require any further information or clarification.

Yours sincerely



Director and Chief Executive