HM Coroners Court
Cater Building
1 Cater Street
Bradford
BD1 5AS

28 August 2026

[redacted]

Dear Madam,

Re: In the Inquest concerning the death of John Bryan Wetton

I write further to receipt of your Regulation 28 report dated the 3 July sent to Alexander House in relation to the inquest of Mr Wetton. Thank you for bringing these matters to my attention.

I would like to assure you that since the sad death of Mr Wetton on the 5 August 2025 significant measures have been put into place at Alexander House in the areas raised in your report.

I will take each matter in turn below:

1. Accuracy and Reliability of Incident Recording at Alexander House

Since these events, a number of steps have been taken to strengthen the reliability, accuracy, and content of incident recording.

Additional training and reinforcement have been provided to all staff in relation to incident recording. Highlighting the importance of clear, factual, and contemporaneous documentation.

In order to ensure that all incident recordings are robust and comprehensive the Registered Manager is now responsible for ensuring that all incident recordings are reviewed within 24hrs. They are also responsible for ensuring that any immediate learning is identified and that any necessary escalation takes place without delay.

To further strengthen this process any incidents that meet defined thresholds for seriousness or flagged as high risk according to internal markers, are subject to additional review and oversight by senior operational and clinical leaders to also ensure that these recordings are comprehensive.

To enhance this process, we have also implemented weekly random ad hoc checks by the Manager and Regional Operations Manager who will now cross reference a proportion

of incident recordings to the residents' clinical records to ensure that all information is accurate and in line with daily entries in the resident's records. These checks will take place across both the day and night shifts. Further monitoring will be by the regional quality lead.

Any themes, trends and learning arising from incidents are escalated through the appropriate Quality and Safety governance structures at Alexander House and discussed monthly with all relevant staff.

2. Incomplete Documentation in Respect of Care Provided to Residents

To ensure that documentation in respect of care provided to residents is accurate and contemporaneous a number of steps have been put into place.

Documentation standards have been reinforced through additional training with all relevant staff including the requirement for records to accurately reflect the care provided, observations made, concerns identified, and actions taken.

The quality of documentation is included within internal quality assurance and compliance reviews which take place by the manager during weekly walk rounds, monthly by the regional operations manager and designated quality lead during their quarterly inspections. Any deficiencies identified through audit or inspection are incorporated into formal accountability action plans with identified owners and timescales for completion.

To further enhance this process random weekly ad hoc checks of care records are being undertaken across both day and night shifts by the Manager to provide ongoing assurance regarding consistency and quality. Any issues arising will be discussed with relevant staff during supervision meetings.

Alexander House will soon also be implementing a new electronic care recording system called Nourish. This system is used by several health and social care providers. It can flag any entries on a resident's record which are incomplete or lacking in sufficient detail and data which will further strengthen the quality of documentation.

3. Honesty and Integrity of Staff Working at Alexander House

I am extremely sorry that you have had to raise this matter with us. The behaviour of staff identified during the inquest process is unacceptable, not representative of the standards expected and does not align with our values or culture. It fell significantly below what is required of anyone entrusted with the care of vulnerable people.

Immediate action was taken when concerns were identified in relation to the three members of staff involved.

- Two of the individuals concerned no longer work for the organisation.

- The remaining individual has been subject to formal management action and is progressing through the organisation's disciplinary process.

These matters have been addressed through the organisation's employment, disciplinary and safeguarding processes. Relevant external referral or notification requirements will continue to be considered and actioned where thresholds are met.

It is important to note that this conduct has not been seen at Alexander House previously with staff committed to being open and transparent in their behaviour. This being reflected also in the recent CQC inspection published in April 2026 which states "The provider had a proactive and positive culture of safety based on openness and honesty ". The CQC further noted that "Staff's approach was friendly, caring and gentle." However, given the seriousness of concerns raised Alexander House has sought wider assurance around staff conduct and culture by a number of measures outlined below.

The importance of honesty, integrity and professional accountability continues to be reinforced with all staff. Staff will continue to be reminded of their responsibility to raise concerns where something does not appear right and of the protections available through whistleblowing procedures.

Duty of Candour requirements and associated processes have been reinforced with all staff including appropriate recording and oversight.

The Registered Manager continues to have staff meetings, supervision, induction, and direct communication with staff where the expectations of speaking up, and reporting concerns continue to be discussed on a regular basis.

Any themes arising from complaints, whistleblowing, safeguarding concerns, and staff conduct matters will continue to be reviewed through Alexander House's governance processes.

Recruitment checks and induction provide further safeguards by ensuring staff understand the organisation's expectations, values, responsibilities, and standards before and during employment. The recent CQC inspection confirms that Alexander House has strong processes in place to ensure "there were enough qualified, skilled and experienced staff who received effective support, supervision and development." The CQC were further assured that "staff were recruited safely, and any specific training needs were identified during the recruitment process."

4. Appropriate and Robust Training for the Registered Manager in Respect of Safeguarding and Investigations

I note the concern regarding the absence of sufficiently robust training and assurance in relation to safeguarding investigations, together with the need to ensure investigations are thorough, transparent, and appropriately independent.

Since the above inquest, the Registered Manager has received additional safeguarding and investigation support to ensure that the principles of how to investigate serious incidents are fully understood, she will receive ongoing supervision and support to ensure that any queries or concerns can be fully addressed.

Serious incidents or unexpected deaths are also no longer investigated solely at service level to ensure independence and appropriate expertise. Investigations are undertaken by appropriately trained investigators, including PSIRF-trained investigators where applicable.

Any such incidents are subject to review through the organisation's patient safety framework. All unexpected deaths are also reviewed through appropriate mortality and morbidity committees.

Any investigation in such circumstances will now require formal review and sign-off through the Patient Safety Committee which will ensure the quality and consistency of such investigations.

Any learning and recommendations will continue to be monitored and disseminated through the Alexander House's Quality and Safety governance structure.

5. Independent Monitoring and Oversight of Events Occurring Within Communal Areas

I have considered the concern regarding the absence of independent monitoring of events occurring within communal areas at Alexander House.

I have considered the potential role of CCTV but recognise that it is not a complete solution and would require careful consideration of privacy, dignity, consent, and residents' rights. Independent assurance however does take place through a number of mechanisms.

These include**:**

- Regular visits and engagement by senior operational and clinical leaders.
- Internal quality inspections undertaken by the Internal Quality Assurance Team.
- Regulatory inspection and monitoring by the Care Quality Commission.
- Engagement and feedback from residents and their families.
- Feedback and oversight from commissioners and other external stakeholders.
- Safeguarding processes and external multi-agency involvement where appropriate.
- Complaints monitoring and thematic review.

- Whistleblowing processes and mechanisms for staff to raise concerns.
- Regular service audits and governance reviews.
- Increased executive oversight of significant incidents and risks.

The Internal Quality Assurance Team provides independent assurance through regular inspections of regulatory compliance, patient safety, documentation quality, care delivery, and service performance. Where required, action plans are developed with clear owners, timescales, and governance monitoring.

Recent external assurance includes a January 2026 Calderdale Council quality inspection, which identified no significant risks requiring intervention and one improvement area relating to person-centred planning, and a February 2026 CQC inspection, including an unannounced first day, after which Alexander House was rated Good in all domains. The CQC report was published in April 2026.

The organisation remains mindful of the importance of continuing to seek assurance beyond regulatory inspection alone. The strengthened internal quality assurance programme and wider governance arrangements therefore provide continuous monitoring rather than reliance upon periodic external inspection.

6. Professional Regulation and Accountability of Staff Caring for Vulnerable Elderly People

The concern raised regarding the absence of a professional regulatory body for some members of staff caring for vulnerable elderly individuals is understood.

The establishment of any new statutory or professional regulatory framework for unregulated care staff is a matter for national government and the relevant regulatory authorities.

However, while the organisation is unable to introduce an external professional regulatory body, we have strengthened the accountability arrangements within our own organisation.

These include:

- Robust safer recruitment processes and pre-employment checks.
- Structured induction processes.
- Clear job descriptions and competency expectations.
- Mandatory and role-specific training.
- Regular supervision and performance management.
- Competency assessment and review.

- Clear disciplinary procedures.
- Safeguarding procedures and escalation processes.
- Whistleblowing arrangements.
- Internal quality assurance and audit.
- Oversight by senior operational, clinical, and executive leaders.

These arrangements are designed to ensure that all staff, whether professionally regulated or not, are appropriately recruited, trained, supervised, monitored, and held accountable for the care they provide.

I hope the above provides assurance that the matters raised have been taken very seriously and have resulted in significant change at Alexander House. Should you have any further queries please do not hesitate to contact me directly.

Yours sincerely

Group Chief Executive Officer