Beech Cliffe Limited

Residential Homes for Adults with Autism
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Dear Sir,

Response to Regulation 28 Report to Prevent Future Deaths

We write in response to the Regulation 28 Order made on 14th November 2017, sent on 6 December 2017 to produce a report setting out the actions taken following the death of Steven Jones. We were granted an extension for our Response to 5 February 2018, for which we are grateful.

Re Record Of Inquest

Before we go on to address the "Matters of Concern" contained within the Regulation 28 Report, we wanted to set out our position in relation to aspects of Record of Inquest as contained within Box 3 and Box 4.

In Box 3 of the Record of Inquest it was recorded towards the end that "*It is unclear whether failures in communication and recording together with decisions taken in the care home influenced the outcome.*"

In Box 4 of the Record of Inquest it was recorded "*Natural Causes in circumstances where it is unclear whether any deficiencies in care or delays in seeking further medical advice contributed to his death.*"

This was not an Article 2 inquest. It was always accepted by Beech Cliffe Limited that there were some deficiencies, of the types referred to, in aspects of Steven's care in the period leading up to his death. What the inquest explored in detail during the course of the evidence was the nature and extent of the deficiencies and whether, on the balance of probabilities, such deficiencies as were found caused or contributed to Steven's death.

Whilst the coroner has no power to correct/amend the Record of Inquest, and whilst Beech Cliffe Ltd is unable to challenge the coroner's conclusion by Judicial Review, the statements to the effect that it was "unclear" whether the deficiencies found influenced the outcome were contrary to the evidence. The issue of causation was explored carefully and at length. There was no medical evidence to the effect that any delay by either the care home (or for that matter the hospital) contributed to Steven's death. There was nothing "unclear" or "uncertain" about that evidence. On the contrary, Professor [redacted] gave evidence that a life saving diagnosis could only have been made with a CT scan. Dr [redacted] evidence, supported by Professor [redacted] was that he wouldn't have ordered one even if he had seen Steven on 28 November 2013. In so far as is it necessary and appropriate for Beech Cliffe Ltd to do so at any later date, they will rely on the evidence given at the inquest by Dr [redacted], Professor [redacted] and Mr [redacted] to show that causation was not established. What the Record of Inquest might have said, particularly in an Article 2 inquest, was that "....it is possible that [the identified failures] contributed to the death". The wording of the Record of Inquest as it is leaves apparent ambiguity on the issue, when the evidence heard makes it clear that causation was not established on the balance of probabilities.

Re Regulation 28 Report

In addition to being dissatisfied these aspects of the wording of Record of Inquest as set out above, we were disappointed and surprised at the statement made by the coroner at the conclusion of the inquest that he would be making a Regulation 28 Report, given that all of the "Matters of Concern" were actually dealt with in the evidence given by Sarah and Paul Ratcliffe during the Inquest hearing. No indication as to any ongoing concern was expressed to either witness during the course of their evidence. To the contrary every indication was given that the coroner was satisfied with the evidence, given both orally and as contained with these witnesses very detailed witness statements, as to steps taken since the death and in response to the identified deficiencies.

An Interested Persons wish to challenge a PFD ruling has been considered in a recent decision of the Administrative Court, in the matter of *R (Dr Siddiqi and Dr Paeprer-Rohricht) v Assistant Coroner for East London* Admin Court CO/2892/2017 (28 September 2017). The judicial review application was dismissed, finding that a coroner has no power to withdraw a PFD report once it has been made. The Court found that the appropriate measure to challenge a PFD report was through the right conferred by 7 (2) of schedule 5 CJA 2009, to make a written response.

It is in the light of that decision that our written response is given.

Each of the Coroner's "Matters of Concern" are set out in italics, and our response to each is set out immediately thereafter.

(1) *Although a system of written recording was in place, concerns of carers were not emphasised nor escalated to seniors either through incident reports or verbally so that opportunities to initiate full investigations by seniors and/or managers were lost.*

Clifton Samuel 'Sam' was one of Steven's one to one carers; he gave evidence at the Inquest on 7 November 2017 that he was able to raise concerns and that had he done so these would have been documented.

Steven's other one to one carer, Clifford Moxon also gave evidence to the Inquest on 7 November 2017. He said that he would go to a senior with any problems and if they had not dealt with it, he would take it higher to a Head of Care. He confirmed to the inquest that in the relevant period, he never had occasion to escalate any concerns. Clifford accepted in his evidence to the Inquest that he could have completed an incident report form or mentioned any concerns in the handover notes and did not do so.

In evidence to the Inquest on 9 November 2017 Sarah Ratcliffe said that if Staff had reported concerns about Steven's symptoms on Saturday 7 December 2013 then she would have taken Steven to the walk in centre in Rotherham. [redacted] gave evidence that any concerns staff had about Steven were never raised with her and neither was she aware of any gossip or tittle tattle.

In her statement dated 4 October 2017 at paragraph 29 Sarah states that any concerns raised by staff about Steven's health and well-being should have been documented and would have been taken seriously, investigated and acted upon.

After Steven's death we became aware of concerns that other members of staff had but had failed to report, record or act upon. Had we been made aware of these concerns at the time we would have sought immediate medical assistance.

The night staff failed to report behavioural issues. These issues were not explored in detail at the Inquest, if they had been Sarah and/or Paul would have explained that in February 2014 they introduced a "traffic light " mood and behaviour monitoring system that the day staff were already using. Paul explained to all night staff that if the resident was awake at night then their mood should be recorded on their night report. Amber behaviour was the trigger for an incident report to be submitted; any behavioural issues would therefore have triggered an incident report which would be seen the next morning by all managers.

In June 2014 the Anticipatory HealthCare Calendar (AHCC) was introduced. [redacted] raised the introduction of this system in her evidence to the Inquest on 9 November 2017. This is a NHS proforma that acts as a criteria-referenced monitoring system for health-related issues in those with learning disabilities. Specific symptoms are listed and given a risk level of Green, Amber or Red; amber and red directly link to required specific staff actions and responses, which are described within the tool and recorded on a Significant Communication Sheet, part of the tool. These range from continued monitoring, through administering pain relief or attending a GP surgery when possible, to contacting emergency services immediately. AHCC is a carer-level tool that is directive in terms of response to specific symptoms. All staff were trained in 2014 how to use it and it forms part of the induction process for all new staff.

Use of the AHCC is audited on a weekly basis, this highlights any remedial training needs and ensures the accuracy of the system is maximised.

In 2016 we piloted a new daily reporting system which incorporates another NHS system, the Disability Distress Assessment Tool (DisDAT). This is another criteria-referenced behaviour monitoring tool and again links to pain identification and prompts staff to complete behaviour monitoring forms on every occasion when a baseline of "no concerning behaviours seen" is changed. The system is designed as an aide memoire, prompting staff to ensure that any reporting relating to health or other issues has been carried out. We rolled DisDAT out fully at the staff meeting on 17 November 2017. Neither the Coroner nor the Interested Parties explored these issues with Paul and / or Sarah at the Inquest so it was not apparent it was in the scope.

(2) *Staff did not appreciate the importance of incident reports and that such reports emphasised illness.*

No evidence was heard that staff did not think incident reports were to include illness. Paul gave evidence to the Inquest on 8 November 2017 that all staff were trained in the completion of incident report forms, which included for illness and when behaviour went from green to amber or to red on the traffic light system. Paul told the Inquest that staff had all completed these forms before, it is not clear why they did not do so in this period for Steven [redacted] told the Inquest on 9 November 2017 that staff had been trained on the completion of incident report forms and had completed them on previous occasions for different behaviours.

Paul gave evidence at the Inquest on 8 November 2017 that he was surprised that no incident report forms reporting health issues were raised and that he would have expected staff working with Steven or the night staff to do so if they had reason to believe he was ill. Paul also confirmed that the completed forms were put in the Heads of Care Office and he would pick them up periodically throughout the day, so within several hours of one being generated.

The night staff now use the DisDAT scale described in the response at (1) above to provide a consistent reporting standard over a 24 hour period.

The AHCC system also removes any confusion about incident reporting, which now relates to purely behavioural issues, although this does not ignore the fact that pain may be a trigger for behavioural concerns. Incident Report forms are completed for behavioural issues. We have body charts to record injury. If a resident vomited faecal matter now this would be recorded on a body chart and detailed in a Significant Communications Sheet.

(3) *In practice staff did not act directly in dealing with illness of a resident, rather channelling medical issues through the registered managers.*

All staff had full first aid training, which includes advising them to call an ambulance in an emergency. Sarah gave evidence to the Inquest on 9 November 2017 that all staff have responsibility to meet the needs of residents and all have authority to contact Doctors etc and all telephone numbers are and were kept in a directory in the staff office, there was no need to go up the ladder for approval before the call could be made.

Paul gave evidence to the Inquest on 8 November 2017 that all staff were trained in First Aid and trained to call an ambulance in an emergency, this was not a decision that had to go up the ladder first.

Various members of staff gave evidence that staff below the managers felt free to raise issues regarding health care with their supervisor who would action as appropriate and that staff felt free to escalate matters or challenge decisions if they thought necessary.

As per Sarah's evidence on 9 November 2017, staff on shift should have made arrangements to see the relevant health practitioner, if there were circumstances where they felt Steven needed medical attention. The head of care, staff and the named carer all worked as a team to ensure the resident accessed that health appointment.

Sarah confirmed to the Inquest on 9 November 2017 that it was always decided in advance who is best placed to take a resident to an appointment. It would always be a named carer so that the resident was directly supported by someone they knew and were familiar with as well as a senior carer/manager or head of care.

The introduction of AHCC in June 2014 highlighted the responsibility staff have in acting on health related concerns. The criteria referenced system and specific actions linked to specific symptoms and risk levels provides a clear guide for direct care staff to act appropriately.

(4) *On the occasion of a serious incident of faecal vomit, staff did not assume responsibility for calling emergency services but telephoned the registered managers who in turn did not appreciate the seriousness of the situation resulting in a delay in transferring the resident to hospital.*

On 7 November 2017 the Inquest heard evidence from [redacted] (Ne'e Hayward) that she was the Senior on duty [redacted] told the Inquest that on the morning of 8 December 2013 Clare Gray reported to her that Steven had vomited faeces. Kelly explained to the Inquest that she made sure that Steven was ok and contacted [redacted] to relay what had happened. [redacted] gave evidence that she could not say for sure if Steven had vomited faeces or if he had passed a bowel motion and then eaten it; the latter had happened previously. The Coroner did not explore this further.

[redacted] explained to the Inquest on 7 November 2017 that in any event she did not call an ambulance immediately because she had checked Steven and he seemed fine and was not distressed. Certainly this was the impression Paul had when he arrived. In his evidence to the Inquest on 8 November 2017 he described Steven as being calm and sat on a bean bag. He said Steven was not distressed or in discomfort.

With the assistance of Sam, Steven's one to one carer [redacted] used the work vehicle to take Steven to the hospital.

The Inquest heard evidence on 9 November 2017 from [redacted] who confirmed that in an emergency situation staff should phone for an ambulance, indeed staff had done so before.

In his evidence to the Inquest on 9 November 2017 Mr [redacted] accepted that calling 999 would not have necessarily meant that an ambulance was immediately dispatched, even if the call had been logged as a high priority, which it would not necessarily be.

Should another urgent situation arise, staff would be directed by the AHCC to contact the emergency services and attend A&E.

(5) *In the case of a non-verbal resident with serious problems very early referral to a general practitioner was not made and when made the resident was not present at the consultation nor was his one to one carer in attendance.*

In evidence to the Inquest on 9 November Sarah confirmed that Monday 25 November 2013 was the first time she was aware of Steven's symptoms, staff had not raised concerns before nor completed any incident report forms. [redacted] reviewed the records and noted that before a bout of diarrhoea that morning Steven had not opened his bowels for 3 days, so thought he possibly had diarrhoea and/or a tummy bug. Sarah therefore asked staff to obtain a stool sample for testing.

The stool sample did not become available until 27 November 2013 and was taken that day to the GP by [redacted] It was Professor [redacted] evidence to the Inquest on 8 November 2017 that the stool sample was taken to the GP in a reasonable time frame and at that time, given Steven's age, diarrhoea was the most likely cause.

Mr [redacted] confirmed in his evidence to the Inquest on 8 November 2017 that a range of professional opinion included the view that Steven's treatment by the Home and decision not to refer him to the GP before 28 November 2013 was reasonable.

As set out at paragraph 17 of her witness statement dated 4 October 2017, paragraph 20 of her witness statement dated 4 April 2016 and in evidence to the Inquest on 9 November 2017 Sarah did not take Steven to the appointment on 28 November 2013 because she was concerned that due to his diarrhoea that morning and the unknown result of the stool sample he could be infectious. Also Steven had previously exhibited anxious and challenging behaviour at appointments. She explained her reasoning to the GP, [redacted] who was happy to proceed with the appointment. When asked by the Coroner on 8 November 2016 [redacted] confirmed that he could have insisted on seeing Steven either at the GP surgery or at the Home.

Usually the one to one carer would attend the appointments, this was confirmed in the evidence of Clifford Moxon on 7 November 2017 who said "check ups at the Doctors me and Sarah used to take Steven to the GP surgery in the car."

[redacted] evidence at paragraph 12 of her witness statement dated 4 October 2017 and when giving evidence to the Inquest on 9 November 2017 was that this was the first time she had

attended an appointment without the resident, it was a one off. Steven was left at the Home with Clifford, his one to one carer because Sarah considered that this would be the best way of supporting Steven.

The Health action plans, which are formal records listing a residents' health appointments and outcomes, provide evidence of residents always attending GP appointments with either their key worker or a member of their care support team that know them well. Domiciliary visits by GP's and other health care professionals will take place when attending the surgery is not possible, again accompanied by key workers or staff who know the resident well.

Yours sincerely

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[redacted]

For and on behalf of Beech Cliffe Ltd