

Christopher Morris
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Date: 28.11.2017

Regulation 28 Report to Prevent Future Deaths

Re: Kathleen Smith

Dear Mr Morris

Thank you for your correspondence of 14th November regarding the Death of Kathleen Smith.

Following the Inquest, I have taken on board your comments regarding head office not being aware of incidents that happen in the individual care homes within Borough Care Ltd.

Borough Care Ltd do expect our Managers to keep us informed of events that happen in the home. However, on this occasion the manager did not inform the Head of Care regarding the fall that Mrs Smith had or the injury that was incurred. This should have happened as a matter of procedure.

I have therefor devised a form that managers must complete on a weekly basis to inform Head of Care of any significant incidents that happen in the home. These incidents are discussed weekly at our Care & Quality meetings and any follow up is actioned by the Area Support for that Home. This form was introduced to all Managers on the 26th October at our monthly Managers meeting and was actioned by the Managers from the following Monday.

Our Quality Manager and Area support team will also ensure that any incidents are discussed on their audit meetings with the Home Manager.

It is unfortunate that the Manager of Lisburne Court at that time did not follow procedure and as discussed in Court the Manager left the service, however if she hadn't left the service her capability to manager was under scrutiny and action would have been taken.

I have enclosed two copies of the form completed weekly by the Manager/Deputy Manager.



Yours Sincerely



Interim Head of Care



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