ANSON CARE SERVICES LTD

Registered Care Homes, and Home Care & Support

CARDREW HOUSE - CARDREW WAY
REDRUTH - CORNWALL - TR15 1SP
Telephone: Redruth (01209) 708688

Mr R. Guy Davies
Assistant Coroner for Cornwall & the Isles of Scilly
The New Lodge
Newquay Road
Penmount
TRURO
TR4 9AA

4 October 2018

Dear Mr Davies

Re: Regulation 28 Letter – To Prevent Future Deaths – Phyllis Letcher, deceased

I am writing in response to your report following the death of Phyllis Margaret Letcher who died in hospital on 12th March 2018, following an unwitnessed fall down eight steps (first floor to the half landing) sustained at our care home, Crossroads House, Scorrier, Redruth, on 2nd March 2018.

You have raised three matters of concern:

1. The absence of live CCTV monitoring of the stairs and other communal areas.
2. The absence of a key fob restricted access through the stair gate.
3. The absence of an alarm in the event that the stairgate is left open.

Following Mrs Letcher's devastating fall we were already reviewing whether there could be anything we might have done differently. Her fall and death shocked us all, and our thoughts have been very much with her family following this tragic accident.

My response below includes both actions we have taken, including reviewing our existing service and processes, and also the legislative framework around which care homes must work in respect of the regulated service we offer.

The three matters of concern you have raised could all impose restrictions on people's freedom of movement and freedom not to be subject to continuous supervision and control. We are obliged to act in accordance with the Mental Capacity Act 2005 (the "MCA") so we invited [redacted] Service Manager for Deprivation of Liberty Safeguards, Cornwall Council, to visit Crossroads House in order to seek his expertise and advice regarding the arrangements we already have in place, and to review our processes. We are bound to consider what would be deemed unlawful restrictions to the liberties of those in our care, and to carry out risk assessments for those affected. You have seen copies of the risk assessments carried out in respect of Mrs Letcher.

While always balancing risk, the MCA requires us to take the least restrictive measures necessary, and to consider what the person would lose through whatever measures might be taken to restrict their activities. It is not about eliminating risk, but is about minimising risk. We are required to assess the benefit (via risk assessment) of what the person would lose by whichever measures are put in place. In other words, we are obliged to balance considerations for a person's safety against their rights to be free to make decisions for themselves. If a person has capacity to make a decision, they must be free to do so, even if we feel that a different decision might be safer or wiser for them.

Often when assessing the care and support needs of an individual, everyday activities are identified that will benefit their lives, but also put them at some level of risk. This requires a balanced and proportionate decision to be made between the needs, freedoms and dignity of the individual and their safety.

The following is taken from the Health and Safety Executive website, risk assessments in care settings.
(http://www.hse.gov.uk/healthservices/sensible-risk-assessment-care-settings.htm)

> "Care assessments should enable people to live fulfilled lives safely, rather than be a mechanism for restricting their reasonable freedoms. Many care providers find it hard not to slip towards a risk adverse approach for a multitude of reasons, for example, resources, bad experiences and a fear of the consequences if things go wrong.
>
> HSE will support decisions to allow everyday activities to be undertaken provided a suitable and sufficient risk assessment has been carried out, documented and reviewed as necessary. This should identify and implement any sensible precautions to reduce the risk of significant harm to the individual concerned"

At Crossroads House risk assessments for likely risks are completed for all service users at the time of admission, and again after a period of observation and familiarisation (and in the future as necessary if or when needs change). Measures are taken in the best interests of the person at that time according to identified risks.

In respect of stairs, the HSE sets out the following guidance, about which I have added my own comments in respect of our care home.
(http://www.hse.gov.uk/healthservices/slips/reducing-risks-stairs.htm)

> **"Reducing the risk of falls on stairs**
> HSE is aware of numerous incidents where patients or residents have fallen on stairs, which have resulted in serious injury or death. There are a number of factors that are particularly relevant to patients and residents and should be considered in the individual's care plan.
>
> Stairs should be in safe condition and be of suitable design and dimensions for their use as set out in Building Regulations Approved Document K
>
> You should consider whether they:
> - are well lit; YES
> - have handrails at an appropriate height that contrasts with the surroundings; YES
> - have good slip resistance properties, particularly at the leading edge; YES - carpeted
> - have clearly marked edges; Carpeted/Glued down from edge to edge,

and in good condition
- are free from trip hazards or obstacle; YES

If patients or residents lack mobility and require extra support, then the stairs should have suitable handrails on both sides. Ideally, stairs should not be steep, winding, curved, nor have open risers. Where individuals are identified as having sight impairment, and are still allowed to use the stairs, the leading edge of the step should be marked to improve contrast between the step and edge. (Mrs Letcher had normal eyesight). These features make the stairs safer for all users, including staff. Wherever possible, wearing of sensible footwear should be promoted.

Where an individual's mobility, balance or other conditions puts them at risk of falls, an assessment should be completed, which can consider whether access to the stairs is appropriate and under what circumstances. Where they are mobile, but are at risk of falls, the views of the individual, care professionals and family representatives should be considered as part of any assessment when deciding whether access to the stairs is appropriate. Some stairs (e.g. steep cellar stairs) may not be suitable for use by residents with mobility or balance issues and may present a significant risk. Where wheelchairs or mobility scooters are used near access points at the tops of stairs, suitable controls should be put in place to reduce the risk of falls.

Where access needs to be restricted for a few individuals, assessment should identify what controls need to be in place. This may include:

- keypads on doors; YES, we have these in areas which are further away from close staffing presence
- emergency release systems (e.g. in the event of fire); YES
- alarms alerting staff to the use of stairs (where staff are always able to respond) NO
- monitoring of stairs (in case of a fall); NO – but staff are always nearby

Discuss this with a Fire Safety Officer if it impacts on fire evacuation. You may also need to seek advice on how to prevent access through external fire doors in a way that they can be released and quickly accessed in the event of fire."

I believe our practices are largely in line with what the HSE has suggested but also in line with the MCA. A mental capacity assessment is undertaken for all service users, and for those found to be lacking the capacity to make specific decisions, the least restrictive interventions are made along with identifying those risks to which the person might be exposed, and their rights. It is then our responsibility to balance any restrictions imposed with any risk, against what benefits would be lost.

The following are excerpts from the Mental Capacity Act 2005 Code of Practice:

"What does 'lacks capacity' mean?
One of the most important terms in the Code is 'a person who lacks capacity'. Whenever the term 'a person who lacks capacity' is used, it means a person who lacks capacity to make a particular decision or take a particular action for themselves at the time the decision or action needs to be taken. This reflects the fact that people may lack capacity to make some decisions for themselves, but will have capacity to make other decisions. For example, they may have capacity to make small decisions about everyday issues such

as what to wear or what to eat, but lack capacity to make more complex decisions about financial matters."

And further:

"However, as chapter 2 explained, the Act's first key principle is that people must be assumed to have capacity to make a decision or act for themselves unless it is established that they lack it. That means that working out a person's best interests is only relevant when that person has been assessed as lacking, or is reasonably believed to lack, capacity to make the decision in question or give consent to an act being done.

People with capacity are able to decide for themselves what they want to do. When they do this, they might choose an option that other people don't think is in their best interests. That is their choice and does not, in itself, mean that they lack capacity to make those decisions."

On admission, Mrs Letcher was assessed as having retained sufficient mental capacity to take responsibility for her own independent mobility around the home at that time. Her care plan documented that in this setting she was at 'LOW' risk of falls and that she was independently mobile without requiring the use of aids.

She was assessed as capable of holding her own fob with which to open doors where other service users might require restrictions. She was also found to have retained the ability to use the telephone in the corridor (one in the corridor of each fob secured bedroom wing) and to read and understand which number to select to call for support to be 'let out' of her corridor if she happened to have left her fob in her room.

She knew and retained the knowledge of what the fob was for. She could also find her way independently to her own corridor and identify her own bedroom. She was seen to be competent at operating the main lift and to finding her way without difficulty between her bedroom upstairs and the 'village' (communal areas) downstairs.

The risk assessments were carried out with the involvement of her family, and the limits to her restrictions (and freedoms) were implemented with their full agreement.
(Link to further information about responsibilities in respect of the Deprivation of Liberty Safeguards https://www.scie.org.uk/mca/dols/at-a-glance)

Mrs Letcher's dementia was sufficiently 'mild' to enable her to dress independently but often without remembering to wash, and to come down, again independently, at different times - sometimes in the early hours - for breakfast. Staff would subsequently encourage and escort her back to her room for assisted care for personal hygiene needs after she had accomplished whatever it might be that she had wanted to achieve downstairs. It was not unusual for her then to forget she had already had breakfast, and to request, and be given, another. She settled very quickly in the care home setting and her medication for agitation and anxiety had been able to be considerably reduced from what had been found necessary to be administered in her own home. The prescription for Lorazepam was an 'as necessary' (PRN) medication, and with the freedom of movement and available distractions and activities within the larger setting of this care home, her anxieties had significantly diminished. Lorazepam was therefore only required to be administered five times during her albeit short time with us. At home I have been given to understand that it was found necessary for her

to receive this several times on most days.

Restricting Mrs Letcher's movements would have resulted in an increase in agitation and anxiety, which at home had only been minimised by one to one support from her very caring family, and by medication. The 'least restrictive' option was applied here, in our view correctly, although we completely accept this lack of constant supervision and sedation will have contributed to her tragic accident. (However, tragic accidents can also happen in everyday life to other people too, who do not have dementia.) We would note, however, that it is not lawful for us to subject people to constant supervision and control where they retain the mental capacity to make their own decisions and we are not able to impose a best interests decision on them to subject them to that level of supervision.

My specific responses to your individual concerns are as follows:

1. The fall was not seen, although it was heard, and staff attended immediately. It is not our view that live CCTV monitoring could have prevented this unless all access to the stairwell was prevented for all service users. This is something that [redacted] (DoLS Service Manager, Cornwall County Council) has said should be 'robustly resisted'. Having live CCTV coverage would significantly increase the restrictions put on all service users, and would not be considered 'necessary or proportionate' and nor would it respect service users' rights to privacy and not to be 'watched' at all times; it would take away dignity for those who would therefore be under constant surveillance. If people did not agree to it, it would be a breach of their right to be free from constant supervision and control.

Live CCTV at all times is also impractical because it would massively increase the costs of care home placements to all parties, including individuals, the local government and NHS, while still not necessarily preventing all accidents. I do however plan to see whether the CCTV coverage in place already (not live) can be extended to cover all levels of the stairwell so that it can be seen retrospectively exactly what might have led up to any future falls if this should happen (in communal areas) so that any specific individual cause (or causes) could be more accurately identified and appropriately minimised if possible for the future. There is current and ongoing huge national debate about the invasion of privacy with regard to the use of CCTV monitoring in care homes, and no clear conclusions are yet available. (In our homes families - with the appropriate consents such as advance directives and Powers of Attorney for Health and Welfare – are welcome to introduce their own devices into bedrooms without reference to us.) If people do not want to live in a home that has CCTV, I do not believe that we will be able to force it upon them (nor would I wish to).

While I can see the benefit of being able to review CCTV footage to ascertain how falls have occurred after the fact, this particular incident probably would not have been preventable if watched by staff from afar. Staffing in care homes is constrained by funding. In my view, it is more useful to have our staff circulating and interacting with our residents so that they can help to prevent accidents in person than to watch people remotely. Staff often provide support when a person appears to be 'wobbly' or in difficulty. Watching from another room may help to pinpoint what happened but having staff available in person allows them to intercede more effectively at the point when a person experiences difficulty.

2. We have considered your concern that we should add key fob access to the stair gates. We have then considered the consequences if key fob access had been in place at the time of Mrs Letcher's admission. Since she had the required mental capacity to make her own decisions in relation to mobility and transfers, it is highly likely that we would have needed to provide her with a fob in order to prevent an unlawful restriction on her movements and

deprivation of liberty. This is similar to her use of a walking stick. While she was unsteady on her feet at times, we were not able to force her to use a mobility aid. An aid had, in fact, been suggested to her before she came to live in our home, but she refused to use it. Similarly, we would not have been able to prevent her from using the stairs by refusing to provide her with a fob, so it is not clear that a fob would have prevented her fall.

There is the further practical complication that such fobs would need to be linked to the fire alarm system so that they release automatically in the event of a fire. This would require extensive additional fire cabling supply to each level. Automatic release of fire escape routes presents its own challenges and risks for people with dementia – especially as the fire alarms can often be 'set off' by service users with dementia.

We are also concerned that restricting access in this way could lead to other falls where some agitated service users may attempt to climb over the bannister rails (as has been prevented by staff before with one service user when being escorted to his room). [redacted] has suggested we seek out a different type of latch which would not restrict opening, but which would 'lock' (latch) shut more easily without displacing the risk elsewhere, meaning that the gates would automatically close behind the individual.

We also have to consider the fact that the gates would release if service users were to activate the fire alarms – which certain of them have done very often in the past, meaning all fob accessible areas will release immediately anyway. We have time delays agreed with the local fire service in order to minimise the risk of unintended exit from the main entrance doors only, giving the staff time to respond to the alarms, to check the fire panels, and to confirm whether this is a false alarm or for real. However, this would still leave the gates open for a period where the risk to service users would increase as they would have come to believe they were always fixed in place.

Most care homes have stairs without gates at all; it may be that a further debate is that we should remove the gates altogether as it is at least a possibility that Mrs Letcher tripped and fell backwards while attempting to close the gate behind her. Had there been no gate at all, it is feasible that she may not have turned and fallen backwards. However, this carries with it other risks.

3. We are looking into whether it is possible to have an alarm which is audible to carers in and around all areas of the home, and which identifies which gate is open. In the case of Mrs Letcher, access was only obtained by her and a couple of other residents who had been assessed as capable of holding a fob, and so this would not have prevented her from having access herself.

This is the only stair accident that has been sustained. 278 different service users have lived or stayed in this home over the years since the home first opened in April 2013, and this is the only accident or near miss on stairs that has happened to a service user. In this time, a small number of them have liked to use the stairs as this is what they have always done at home. If they have appropriate mobility, and the capacity to make this decision for themselves, we have no right to restrain them.

We very much recognise and regret the distress and grief which the family has suffered due to Mrs Letcher's shocking and untimely death, and wish to do anything in our power to avoid preventable accidents whenever this can be achieved without causing further agitation or anxiety to people with dementia, nor where this might displace one risk only to increase another risk elsewhere.

[redacted] Service Manager for Deprivation of Liberty Safeguards (DoLS) pwilkins@cornwall.gov.uk has expressed his willingness for you to contact him if you wish for further information about anything his role and skills might assist with in respect of this.

Yours sincerely,

[redacted]
Managing Director
For Anson Care Services Limited