Sunnyside Nursing Home
41 Marshall Terrace
Cross Gates
Leeds, LS15 8EA
[redacted]

Office of the Senior Coroner
Coroner's Office and Court
7 Northgate
Wakefield
WF1 3BS

15 SEP 2021

[redacted]

Dear Madam

I am writing in response to, and as required by, your letter of 23 July 2021. The action plan which you requested is attached, as are explanatory notes with background details.

The manager and I are both fully aware that we were not fully prepared for the inquest and can only offer our apologies. Despite[redacted] having worked in the sector for over 30 years and my involvement in providing care across 5 care homes for 16 years, neither of us had ever been involved in an inquest before. This gap in our knowledge led to our not considering fully the documents to be disclosed: there are records which are whole-home and contain details of all residents which are not included in care plans. These include the written shift handovers, the meal-time check lists, the visiting records, the computerised nurse call bell records for bedrooms, and the twice daily covid symptom checks: their presence in the disclosure would not have negated the inconsistencies between the room charts and other records but would have filled in many of the lacunae identified.

Unfortunately, we were not aware that there had been any concern about anything other than The late Mr Dickinson's pressure are care, unti[redacted] took the stand at the inquest. We had received a phone call querying pressure wounds on 2 August 2020; however, no concern was raised, and we were informed by the consultant geriatrician assigned to our community care beds that this had been resolved as the as the hospital's tissue viability nurse conducted an examination and noted that the skin problems were not pressure wounds but caused by moisture. We do not know why a safeguarding concern was not raised about the other aspects of care as we have no access to GP or hospital records.

Neither were we made aware of the area of concern during our conversations with coroner's office about providing our records and attending the inquest. We had rung the coroner's office to ask if we required legal advice and we had consulted the Royal College of Nursing who informed us that this was not necessary as we had not been notified that we were

persons of interest. We fully accept the coroner's comments about inconsistencies and confusion arising from our documents, for which we apologise, but believe that we may have been better able to respond to questioning if we had been better prepared and had received legal advice and preparation.

More importantly, if we had been advised of the concern more timeously by a complaint or safeguarding alert being received from the hospital, it would have enabled an improved investigation by the care home while memories were fresh, and staff were still in post; and would have enabled any learning to be identified while we were still providing Community Care Beds. As [redacted] stated at the inquest, we had given notice of our intention to withdraw from the contract in April 2020 and the contract ceased accordingly in April 2021.

We have shared our action plan with [redacted] at the Care Quality Commission.

Yours faithfully

[redacted]
Director

For and on behalf of Bluebell Care Services Ltd