STRICTLY PRIVATE AND CONFIDENTIAL

Mr Zafar Siddique
Senior Coroner, Black Country Area
The Black Country Coroner's Court
Jack Judge House
Halesowen Street
West Midlands
B69 2AJ

14 January 2022

Dear Mr Siddique

Report for the Prevention of Future Deaths following Inquest into the death of Ms Redding

I am writing to you on the behalf of Cherish Homecare Limited ("**Cherish**") further to the Inquest into the death of Karen Redding and the Report for the Prevention of Future Deaths dated 18 November 2021.

Cherish Homecare Limited

Cherish was established as a homecare agency in 2002 and since this point, we have been providing care and support to a wide-range individuals, with a wide range of needs, within their own homes and in the broader community. The care we provide to service users can range from a few hours a week to live in care provided on a 24-hour basis.

We support older people and younger adults, with ranging levels of need. The type of care provided can include personal care (such as support with washing, bathing, and showering, continence care and assistance with dressing), nutritional care (including the preparation of drinks, light meals, breakfast, hot meals/ snacks and managing food hygiene) and practical support (including making/changing the bed, laundry/ironing, shopping, and light household duties). We are also able to provide sit-in care (more closely monitored day and/or night support for those living alone), live in care (where a carer lives in a service user's home and provides care on a long- or short-term basis allowing a more acute care service to be delivered) and reablement support (care following discharge from hospital, recovering from accidents or recovery for the effects of an illness etc).

At Cherish, we take the view that all the individuals we support, deserve a high quality and personalised service, which is regular and on time, every time. We believe in self-directed support and that everyone should have choices and control over their own lives and to be able to make decisions about their chosen lifestyle. We value the care and support each individual receives from their relatives or others close to them and aim to work alongside them and include them in the service we provide to their loved one.

Our key objective is to ensure that the independence, privacy, and dignity of all individuals we support, is maximised to the full through comprehensive, high quality personalised care, delivered to meet their specific individual needs and choices.

[redacted]

Ms Karen Redding

In the first instance, I wanted to take the opportunity to confirm some points regarding the care delivered to Ms Redding. Cherish provided care to Ms Redding from 9 November 2020 to 24 March 2021. Ms Redding lived with her partner – [redacted] - who was her main carer and next of kin that supported Ms Redding in any decision making. Ms Redding was 60 years of age and had full mental capacity and acumen to make her own decisions. Since the start of Ms Redding's package of care, Cherish was not involved in Ms Redding's medication and all medication needs were managed and coordinated by Ms Redding herself and [redacted].

Actions taken following the death of Ms Redding

On the carer's arrival on 25 March 2021 to deliver the morning call, they were informed by a police officer that Ms Redding had passed away that morning; at this stage, the cause of death was unknown. Notwithstanding this, an internal investigation was immediately commenced to consider the circumstances on 24 March 2021 and what lessons could be learnt to prevent similar circumstances arising in the future. As part of this investigation, the following steps were taken.

- On 25 March 2021 all records on the system were examined and an emergency office staff meeting was undertaken. During this meeting, we introduced the following procedure for where a medication overdose or a similar incident where the service user requires medical assistance, occurs –
    - Regardless of what service users, family members or any other next of kin may want, staff must take the initiative to seek medical help and support i.e., contacting the GP, Pharmacist, NHS 111 or 999.
    - Though service users or family members can be awkward in such situations, we should not be concerned of potential risk of complaints due to overriding their decisions and instead we should call for the appropriate medical assistance.[1]
- Also on that day, all care staff involved in Ms Redding's care on 24 March 2021 were contacted and they were requested to attend a meeting on 26 March 2021.
- On 26 March 2021, a meeting was conducted with all care staff who attended Ms Redding's calls at lunch, tea, and bedtime on 24 March 2021. We also met with these care staff individually and obtained statements.

Evidence collated suggests that the office was made aware by the visiting care staff that Ms Redding had consumed more oral medication than the recommended dosage. This information was confirmed by Ms Redding and her partner. Office staff advised [redacted] to take the appropriate action of contacting the GP or 999 for an ambulance, and in turn, [redacted] assured the office staff and care staff, on more than one occasion, that he would if required. Evidence of feedback collected from the office staff also indicates that if the office staff members on duty had somewhat of an inkling that [redacted] would not follow the advice given to him by the office and care staff members, then carers would have been instructed to call out for paramedics themselves.

[1] We would also notify / report to the Care Quality Commission and local authority safeguarding team as appropriate.

[redacted]

As an organisation, Cherish is committed to continuous learning and driving improvement. We recognise the opportunity of learning lessons from such incidents and improving our practices at an individual level as well as at an organisational level.

In the 19 years of Cherish providing care, no incident of this type has ever occurred. Management has reviewed the effectiveness of medication policies, procedures and working practices to ensure such circumstances are not repeated.

The following measures have been implemented as a preventive means to ensure such circumstances do not arise again in the future.

1) The medication policy, procedures and practices were reviewed and revised accordingly. The procedure discussed above for medication overdoses or similar incidents where the service user requires medical assistance was implemented immediately.
2) All office staff were made aware of the procedure for seeking medical assistance discussed above, through staff meetings.
3) Shortly after the incident, all care staff involved received refresher training in medication including the significance of calling for paramedics regardless of notions displayed by service users and/or their next of kin. All other care staff were contacted via text message and notified of the procedure for seeking medical assistance.
4) A medication overdose policy was introduced. It should be noted that this policy confirms the procedure discussed above and states the following: "***Remember to contact the office asap to inform them of the situation at hand. Office staff to call 999 or NHS 111 regardless of whether the service user or their Next of Kin agrees or not***".
5) Medication refresher training was delivered to all care staff members in the company in July, August, and September 2021.
6) New staff will be introduced to the medication overdose policy and the procedures for seeking medical assistance through their induction process.

We noted your comments in the Report that our management team may wish to consider reviewing the training and guidance to care staff relating to handing items to service users and checking the contents of boxes. With consideration of the circumstances surrounding Ms Redding's death, we have, as directed, reflected, and reviewed on Cherish's approach to this issue and the training and guidance provided to staff. We have concluded that the general approach we currently adopt and instruct care workers to take remains appropriate.

It is very typical for carers to ask a service user before they leave the call if they can assist them any further; this may be through handing items to them. Whilst circumstances should be considered on a case-by-case basis, as a general approach, where a service user has full capacity and asks a carer to hand something to them, we would expect a carer to hand that item to them, without further questions or for example checking the contents of the bag, box etc. It is paramount that carers and Cherish respect people's privacy and promote their independence; it is not for our carers to unreasonably control what people with capacity to make their own decisions can and cannot do or to "police" their lives. In this instance, Ms

[redacted]

Redding controlled her own medication and had mental capacity to do so; Cherish was not commissioned to provide support with medication and so it was expected and typical that Ms Redding would handle her own medication.

We would, however, expect a carer to ask questions or check the contents of bags, boxes etc in a respectful and appropriate manner if they were asked to hand an item to a service user and they had specific concerns about doing so (so for example, if the service user lacked mental capacity, was presenting as confused or expressed suicidal ideations). If carers had any concerns regarding what they were being asked to do following questions or checking, we would expect them to call the office. Where carers have a concern of the type mentioned, it is highly likely that they would call the office anyway (regardless of whether they were asked to hand over an item) to report and seek guidance as to appropriate actions / next steps. This would be in line with the training they receive. Such a concern did not arise on the day in question in relation to handing the box to Ms Redding and so we would not have expected the carers to have refused to hand it to her.

In addition to the above, the following measures are in place to ensure service users continue to receive safe and effective care. Cherish conduct monthly audits of the daily records and MAR charts for each service user. We audit a sample of the daily records and charts for each service user from a few days of each week. This audit is conducted by our specific member of office staff with responsibility for quality assurance.

If any concerns are raised through the audit these will be investigated. The nature of the investigation undertaken will depend on the circumstances, but generally where a concern regarding reporting and recording by a carer arises, we will ring that carer and speak to them about it. We will also follow this up by sending them a message reiterating the importance of logging and reporting correctly. Every 3 months we review the results of the audits to identify any patterns or trends and we will respond to any identified patterns / trends accordingly.

We also conduct monthly courtesy calls with service users to assess whether they are happy with the care being provided to them. There are a number of set questions that we ask. The calls may give rise to the need for action and this need will be recorded, as will the action taken. Often during these courtesy calls, service users will praise staff and these compliments will be passed on. We analyse the results from the courtesy calls on a quarterly basis to identify any patterns or trends and we will respond to any identified patterns and trends accordingly.

Specifically in relation to medication, we would note that almost all of the calls Cherish deliver are double up calls and during these double up calls, carers are required to work together when administering medication to ensure it is done correctly. For example, one carer will check the other has selected the right medication, dosage etc. One carer will usually complete the daily records but the second is required to record and sign to verify the actions taken, including where applicable, that the medication was administered correctly. If during the audit we identify the second carer has not written in the daily records as described, this will be picked up and actioned with the relevant carer.

[redacted]

Medication is typically discussed during supervisions with carers (alongside the importance of recording). We also conduct spot checks with carers every 3 months which will cover medication. We used to conduct these spot checks on an annual basis, however we took the decision to increase the checks to every 3 months from September / October 2021 to respond to feedback from staff as to what would be helpful.

I would like to take this opportunity to express my sincere condolences to Ms Redding's family and friends. She was well regarded by those who cared for her and will be missed.

Please do not hesitate to contact me should you have any questions.

Yours Sincerely

[redacted]

Managing Director
Cherish Home Care Ltd

[redacted]