

Assistant Director
Tel:
Mob:
Email:

Date: 15 August 2014

Ref:

Private and Confidential.
Penelope A Schofield
Senior Coroner
Coroner's Office
West Sussex Record Office
Orchard Street
Chichester
West Sussex
PO19 1DD



Dear Ms. Schofield

Re: Inquest into the death of Stanley Bere - 29 May 2014.

Thank you very much for your letter and report relating to death of Mr. Bere.

We have tightened up our reporting systems, particularly ensuring all falls, accidents and "near misses" are recorded, and updating on any accident or incident. A more secure system of archiving has been introduced. We have also found a copy of a receipt we asked the coroner's officer to sign when taking the records, as she had no letter with her. I have enclosed a copy for your records. The home manager regularly checks that issues are recorded and followed up in his regular auditing of documents. Staff are aware of the consequences if they do not follow correct procedures. These improvements were put in place immediately following the inquest.

It is unfortunate that although the care staff called the general practitioner, when Mr. Bere was sent to hospital, the hospital staff x-rayed his hip rather than his ankle. When he returned to the home, the general practitioner was called and staff were advised to wait a couple of days and then contact the general practitioner again. It was when he was contacted again that Mr. Bere went back to hospital and an x-ray revealed the fracture.

The Kardex system does record that on 19 November 2011 Mr. Bere's dressing came off and staff referred him to the district nurses. They took over his care and redressed and cleaned the wound. There are four recorded items in the Kardex at that period of time. District nurses keep their own record of treatments for residents. We now ensure that we have a copy of their records and are aware of the current situation with each resident.

We appreciate that this report is specifically for us and are happy to provide details of our actions but it is disappointing that there is no mention of the verbal summing up of the narrative verdict where it was acknowledged that there were missed opportunities by all parties involved and that other professionals also had a part to play in the outcome.

We note that we were given 56 days to respond to your report, which was dated 4 July 2014. However, the accompanying letter sent by your office is dated 24 July 2014, thus giving us only 35 days to respond.

Yours sincerely

Assistant Director of Older People's Services.