Regulation 28: REPORT TO PREVENT FUTURE DEATHS

.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

DOWNHAM GRANGE CARE HOME owned by KINGSLEY CARE HOMES LIMITED
9 Clackclose Road
Downham Market
Norfolk
PE38 9PA

1. CORONER

I am Jacqueline LAKE, Senior Coroner for the area of Norfolk

2. CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

3. INVESTIGATION and INQUEST

On 06/12/2021 I commenced an investigation into the death of Lilian Bernadette BEHRENDT aged 91. The investigation concluded at the end of the inquest on 19/05/2022. The medical cause of death was:

1a) Bronchopneumonia
1b)
1c)
1d)
2 Aortic Valve Stenosis, Systemic hypertension

The conclusion of the inquest was: Natural causes. Mrs Behrendt developed symptoms of sepsis which were not identified and treated until shortly before her death.

4. CIRCUMSTANCES OF THE DEATH

On 28 November 2021 Mrs Behrendt did not appear well at breakfast although her observation recordings were within normal range. Mrs Behrendt's condition deteriorated throughout the day and at 13:49 hours 111 service was called. After further discussion the ambulance service was called at 15:38 by the 111 service. The call was incorrectly graded. The care home records continue to record Mrs Behrendt as being "content". Mrs Behrendt continued to deteriorate and the ambulance service was called again and the call was upgraded to a Category 2 call at 19:27 hours. The ambulance service arrived at 20:14 hours and Mrs Behrendt was taken to Queen Elizabeth Hospital where she was diagnosed with chest sepsis and was noted to be very unwell. Despite active treatment, Mrs Behrendt's condition deteriorated and she died later that evening.

5. CORONER'S CONCERNS

During the course of the inquest, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances, it is my statutory duty to report to you.

The matters of concern are as follows:

1) The records relating to Mrs Behrendt referred to her as being "content" throughout the 28 November 2021 and did not refer to her deteriorating condition. There was no record of the result of the observations taken throughout the day or why these were taken, i.e. Mrs Behrendt's condition was deteriorating and at the request of her family due to their concerns with regard to Mrs Behrendt's poor presentation.
2) The evidence was that the Nurse taking the observations on 28 November 2021 did not have access to a mobile recording device, which staff are given to use at the Home specifically to record results, although she did have access to a computer on the Unit to input the information. Evidence was heard that the number of mobile recording devices has now increased to 12, which "should be adequate", but that "they do get lost and broken". As at the day of the inquest 10 were available to staff to use.
3) Evidence was originally heard *t*hat the Nurse in Charge had been "dismissed" following Mrs Behrendt's death. At the inquest evidence was heard that "the probationary period had not been extended". Evidence was heard that the nurse may not have been aware that she was required to record every action and it was accepted that the records in general were "abysmal", namely those completed by other members of staff.
4) The Nurse in Charge had contacted another member of staff to comment on Mrs Behrendt's general presentation as she [NIC] had not worked with Mrs Behrendt for over a month, having been placed on a different Unit.
5) It was unclear from the Home records whether a DNACPR and a ReSPECT form were in place. The Manager had not seen a paper copy and was unclear as to the position.
6) The evidence revealed a lack of ownership for overall running of the Home, with no one person having or taking responsibility and accountability for the residents, referring to, e.g. Nursing Lead being responsible for DNACPR, nurses "knowing" they should complete the results of observations taken and checking to see that action had been taken Downham Grange Care Home is a relatively small home with a maximum of 62 residents. At the time Mrs Behrendt was a resident the Home had in the region of 48 residents. She had been there since 2018 and the present Manager since May 2021. The Manager had little knowledge of Mrs Behrendt, knowing of her "in passing".

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

7. YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 August 2022. I, the coroner, may extend the period.
Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

8. COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

I have also sent it to:

- Care Quality Commission (CQC)
- Healthwatch Norfolk

who may find it useful or of interest.

I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any other person who I believe may find it useful or of interest.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest.

You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.

9. Dated: 08 June 2022

Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
County Hall
Martineau Lane
Norwich NR1 2DH