Regulation 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **WINDMILL HOUSE CARE HOME owned by RUNWOOD HOMES SENIOR LIVING** **14 Browick Road** **Wymondham** **Norfolk** **NR18 0QW**
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 21 February 2022 I commenced an investigation into the death of Janice HOPPER aged 74. The investigation concluded at the end of the inquest on 17 November 2022. **The medical cause of death was:** 1a) Alzheimer's Dementia 1b) 1c) 2) Chronic Kidney Disease, Type 2 Diabetes Mellitus **The conclusion of the inquest was:** Natural causes
4	**CIRCUMSTANCES OF THE DEATH** Mrs Hopper was discharged from hospital to Windmill House Care Home on 31 December 2021. On 14 January 2022, Mrs Hopper's condition deteriorated and emergency services were called. Mrs Hopper was taken to the Norfolk and Norwich University Hospital where she was diagnosed with reduced consciousness and hyperglycaemia. She had evidence of acute kidney injury. With treatment Mrs Hopper's condition improved and she was being considered for discharge. Her condition then deteriorated and she died on 12 February 2022.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. Mrs Hopper had dementia. The Care Plan was not prepared with input from Mrs Hopper's husband. 2. Evidence was heard that some information in the Care Plan purporting to relate to Mrs Hopper was "cut and paste" from another resident's Care Plan. 3. The Care Plan contained several inaccuracies such as referring to Mrs Hopper as a "man" and saying she enjoyed taking her meals in the communal dining room, when she was confined to her room due to Covid 19 isolation. 4. The Care Plan provided for Mrs Hopper to be weighed weekly. She was not weighed weekly. 5. Mrs Hopper was diagnosed with Diabetes. The Care Plan provided for Mrs Hopper's blood sugar levels to be checked twice weekly. This information differed from information contained in other documents. Mrs Hopper's blood sugar levels were not checked until the day she presented as unwell and was admitted to hospital, some fourteen days after admission. 6. The Care Plan provided for Mrs Hopper to be on a controlled diet due to her diagnosis of Diabetes. Evidence was heard this meant "low sugar" and staff were made aware of this orally. There was no record of any specific diet relating to Mrs Hopper or to a resident with a diagnosis of diabetes. 7. Due to concerns about Mrs Hopper's intake of fluid, there was a recommended daily fluid intake. The amounts of fluid given to Mrs Hopper and the amounts she drank were estimated by staff. 8. The amount of fluid intake was not always recorded in the notes by the staff who had estimated the amount consumed but relayed to another member of staff who would complete the records. 9. There were concerns about Mrs Hopper's food intake. It is not clear from the evidence that the amount stated in the records as being consumed was accurate. For instance, on several occasions she was noted to have consumed large amounts of fluid in one go and to have eaten more than one meal within a short space of time. 10. Mrs Hopper was discharged from hospital with medication including Morphine Sulphate. The written instructions were she was to be given a dose four times a day "as and when required". Mrs Hopper was given seventeen doses of Morphine Sulphate as a matter of course, regardless of whether this was required, before this was stopped by a General Practitioner. 11. Care Plans are not regularly reviewed or audited by senior members of staff. 12. An internal investigation carried out by the Care Home recommended review of Fluids and Nutrition be audited regularly and a "lessons learnt" document would be created for all staff. There is no evidence that these steps have been taken.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have 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 January 20, 2023. 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: • [redacted] – husband 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 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 by the Chief Coroner.
9	**Dated: 28/11/2022** J Lake **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH