CORONER'S OFFICE
DISTRICT OF HERTFORDSHIRE

The Old Courthouse, St Albans Road East, Hatfield, Hertfordshire, AL10 0ES
DX: 100702 Hatfield
Tel: 01707 292780 Fax: 01707 897399

MR EDWARD G. THOMAS Senior Coroner
MR GRAHAM DANBURY, Dr FRANCES CRANFIELD, ALISON GRIEF, EDWARD SOLOMONS
Assistant Coroners

11 November 2013

Compliance Manager
Care Quality Commission
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Your Ref: ---
Our Ref: 3121-2012

Dear

Re: John Gwynfryn MORRIS, deceased

I am writing to you under the provisions of Schedule 5 (paragraph 7) of the Coroners and Justice Act 2009 which came into force in July of this year. This reenacted the provisions of the old Rule 43 of the Coroners Rules 1984. Attached to this letter is information concerning the new rules and regulations from which you will see, requires a written response and copies of this letter and the response received from you to be forwarded to the other interested persons identified at the Inquest in accordance with the list attached. You will note that I am also sending a copy of this letter to the Hertfordshire County Council who were involved in the registration of the home as a dementia unit.

On the 6th November 2013 I concluded an inquest into the tragic death of John Gwynfryn Morris (who everybody knew as Gwyn). I have attached a copy of the Inquisition from which you will note that Gwyn died of 1a Left ventricular failure, 1b Severe Ischaemic Heart Disease and Hypothermia, II Dementia. I recorded a Narrative Verdict and outlined in the circumstances in some detail the manner by which he came by his death. You will note that he suffered from dementia but was described by everyone working in the residential home as a very contented pleasant gentleman who liked to help and wander around the unit. Gwyn cared for his wife until she died. She also suffered from dementia but then, according to his daughter, Gwyn also begun to suffer with dementia. He endured distressing placements in Shropshire which was at that time his home area. He had been sectioned under the Mental Health Act and the EMI Unit to which he was discharged only lasted a very short time. Attempts at looking after him at home were unsuccessful and he was moved to Willowthorpe Residential Home, High Street,

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Stanstead Abbotts Hertfordshire where his daughter and the care staff reported that he had settled well but that he would wander as Gwyn loved the outdoors. On three occasions he left the home, one time walking some six miles to Harlow Railway Station. An Interim Deprivation of Liberty Order was made and further security measures were put in place at the home as he had escaped through a window.

Gwyn went missing in the early hours of the 6th December 2012 and as you can see from the Record of Inquest, toxicology confirmed therapeutic levels of his medication and therefore it is likely that he died quite shortly after he left the unit. The river Lea runs through Stanstead Abbotts very near to the home. An alarm went off on a door when opened earlier but had to be deactivated to bring somebody back into the home. On the night he left the home there were two staff on duty for twenty four residents. Staff had to deal with a lady who suffered a fall and coax Gwyn back in from the enclosed courtyard adjacent to a fire door the alarm of which had activated and opened. It appears that that was the door through which Gwyn subsequently left the home as all the window locks were found to be secure.

I heard from a care assistant that some of her duties involved laundry, setting tables for breakfast and other tasks that a representative from Hertfordshire County Council described as tasks appropriate for domestics. Staff both during the day and night need to be able to give attention to residents. Those suffering from dementia may not sleep well and having good mobility may well be inclined to get up and wander around in their confusion.

I know that many hospitals are looking carefully at their staffing levels at night particularly in the wards where patients suffer from dementia and may be at a risk of falls through wandering and I am drawing this case to your attention so that you and your inspectors can look carefully at whether staffing levels for night time are adequate to meet the various needs of all the residents/patients in residential, nursing and hospital environments. It seems to me that only two members of staff caring for over twenty four residents, some of whom suffer from dementia and are restless, is not enough to meet all the complex needs, especially with their other duties over a long shift of almost twelve hours.

I would look forward to hearing from you in due course and appreciate your interest in this matter. The schedule requires a response from you within 56 days of receipt which I calculate is the week ending 10th January 2014. Please let me know if there are difficulties in complying with this timescale or wish to discuss this matter further. I am willing to extend this deadline with good reasons.

Many thanks for your anticipated assistance in this matter,

Yours sincerely

Edward Thomas
H M Coroner