Keoghs

HM Assistant Coroner
David Urpeth
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Our Ref: CDN/T10295225
Your Ref:
Date: 27 February 2019
Please Ask For: Chris Newton
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Dear Mr Urpeth

Prevention of Future Death Report touching upon the death of Mr John Duckenfield

I am instructed by Brancaster Care Homes Limited to respond to your regulation 28 report dated 18 December 2018.

This letter responds to the report and includes details of action taken and the date it was taken.

1. Your concerns

My client is concerned at your findings, conclusions and regulation 28 report. We think it is important to note the following points so that your concerns can be put in context:

- At the time of his admission to Pexton Grange care home on 12 December 2017, Mr Duckenfield was suffering from a number of active medical conditions as evidenced by the statement of [redacted];
- Pexton Grange cared for Mr Duckenfield with non-medical care staff and nurses. The staff used proforma clinical notes to record their involvement with Mr Duckenfield. You had sight of these notes. They record regular interaction with Mr Duckenfield, staff comments, interaction with his family and outline the care that Mr Duckenfield received;
- Nurse [redacted] said in evidence at the inquest that he carried out more observations of Mr Duckenfield than he recorded. My client accepts however that records must be accurate and that it was a failing not to make an accurate record but does not accept that there was any intention to mislead;
- On 29 December 2017 and the morning of the 2 January 2018, Doctors [redacted] respectively, examined Mr Duckenfield and saw that his observations were normal. Dr Berry said that the oxygen aspirations could fluctuate quite significantly on a daily basis;
- The clinical notes indicate that observations were taken by Nurse [redacted] on 30 December and 2 January. The staff at Pexton Grange carried out regular interaction and

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assessments of Mr Dunkenfield and [redacted] (who was employed by the safeguarding team and interviewed [redacted]) told the court that this was one method of monitoring a patient – the other being the taking of their observations;
- Non-medical staff completed fluid charts;
- It is agreed that his cause of death was 1a Progressive neurological disorder or unknown aetiology and pneumonia; 2 Alcohol related liver disease.

In light of the above, our client's position is that Mr Duckenfield received reasonable care whilst he was at Pexton Grange despite the fact that daily observations were not carried out. He was receiving constant attention and assessment from the care home. It is also our client's view that Mr Duckenfield died from natural causes and there was no evidence to suggest that the omission to take daily medical observations contributed to the sad death.

2. <u>Response – action taken</u>

My client is constantly reviewing its systems and striving to make them as robust as possible. Lessons have been learned from this investigation and acted upon. In summary:

- I attach a procedure regarding observations (resident observation P52) and the recording of such (specific observations F13u and monthly observations F13l). The objective of this procedure is to:
    - ensure that the residents are observed relevant to their condition/diagnosis;
    - ensure that the observations are recorded;
    - make sure relatives are fully aware of the observations and treatment required as a result of the observations; and
    - ensure changes in baseline observations are reported to other professionals.
- My client organised staff training to ensure that record keeping is undertaken contemporaneously and follows NMC guidelines. All registered nurses attended this training which took place on 3, 8, 9 and 10 January 2019;
- All registered nurses were issued with the new procedure during their training in January 2019 and signed to acknowledge their understanding and receipt of it;
- Audit checks on care records are undertaken by home managers but also by other home managers external to the home on a scheduled monthly basis. These audits are ongoing;
- My client already undertakes annual audits of homes. The 2018 audit for Pexton Grange of residents, staff and visiting professionals was positive and action has already been taken to rectify any issues arising.

My client notes the concerns in relation to Nurse Bogdan and your referral to his professional body. On 17 January 2019, Nurse [redacted] successfully completed an observations training module on National Early Warning Score (NEWS2). I attach his certificate. NEWS2 is a guide used to quickly determine the degree of illness of a patient. It is based on the vital signs, respiratory rate, oxygen saturation, temperature, blood pressure and pulse. Nurse [redacted] has also been issued with the new observation policy and signed to acknowledge his understanding and receipt of it.

My client wishes to conclude by re-iterating that it sincerely regrets the death of Mr Duckenfield but trusts that the steps taken since demonstrate its commitment to addressing your concerns in relation to observations and record keeping. New procedures are in place with internal and external oversight to help ensure compliance.

Please do let me know if you need any further information.

Yours sincerely

[redacted]

Keoghs LLP