Regulation 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1. Managing Director
   Crystal Care Ltd
   46 Holway Road
   Sheringham
   Norfolk
   NR26 8HR

2. Manager
   Sapphire House
   56 Long Lane
   Bradwell
   Great Yarmouth
   NR31 8PW

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 07/08/2018 I commenced an investigation into the death of James Owen DELANEY aged 37. The investigation concluded at the end of the inquest on 19/06/2019. The conclusion of the inquest was: Natural causes aggravated by neglect

1a Diabetic Ketoacidosis
1b
1c
II

4 CIRCUMSTANCES OF THE DEATH

Mr Delaney was a resident at Sapphire House Care Home. He was an insulin controlled Diabetic and was not always compliant with his medication. The consequence of not taking his insulin was recognised as possibly life threatening. Care Home protocols included medical advice be obtained on a service user not taking medication for twenty-four hours. On 25 and 26 July 2018 Mr Delaney refused his two doses of insulin, which was noted in the records. On 27 July Mr Delaney became unwell with sickness and diarrhoea and again was noted not to have taken his medication. Mr Delaney was placed on 15 minute observations. Overnight Mr Delaney was found on the floor where a bed was made for him. On the morning of 28 July 2018, the final recorded observation of Mr Delaney was at 10 am when he remained unwell. At the next observation Mr Delaney was found unresponsive. Emergency services were called at 10.43 am. Mr Delaney was pronounced dead at 11.42 am.

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 will 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. There are several general Policies and Procedures in place and individual documents relating to service users. Whilst staff are now given ring-fenced time to read and understand those documents on entering the Home, the evidence is that time is not set aside to refresh themselves at regular intervals with regard to this information;
2. The Medication Policy covering all medication, all service users at all Homes within the Crystal Care umbrella organisation, provides a GP should be called if medication is not taken for 24 hours. At Sapphire House staff have been sent an email requiring them to call a GP should a service user refuse one dose of medication. This is not a standard procedure across all Homes and could lead to confusion, particularly should staff transfer between Homes and on new staff joining who may not have access to the email.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe 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 20 August 2019. 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] (via solicitor)

Care Quality Commission (CQC)

and Healthwatch Norfolk who may find it useful or of interest.

I am also under a duty to send the Chief Coroner a copy of your response.

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: 25/06/2019

.....JLake.....

Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich NR1 2TN