IN THE SURREY CORONER'S COURT

IN THE MATTER OF: JOYCE MAY DENNIS

The Inquest Touching the Death of Joyce May DENNIS

A Regulation 28 Report – Action to Prevent Future Deaths

	• **Roseland Care Home (formerly sister home to now closed Roseacre Care Home)**
1	**CORONER** J. Russell-Mitra, HM Assistant Coroner, for the County of Surrey
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** An inquest into the death of Joyce May Dennis concluded on 26th October 2021. I found that the cause of death was: I a Acute pulmonary oedema

	Ib Acute myocardial infarction Ic left circumflex coronary artery thrombosis I concluded with a narrative conclusion as follows: On 9th September 2019 Joyce May Dennis, who was a resident of Roseacre Care Home, Banstead, became unwell with a minor viral illness. On the same day she was seen by her general practitioner who advised that her condition was to be monitored and observed.Thereafter her condition was not sufficiently monitored or observed and she became significantly more unwell by Wednesday 11th September. During this time the general practitioner was in the building on a routine visit however medical attention for Joyce was not procured from him or any other source. After this date she continued to deteriorate with medical attention being sought on the afternoon of 13th September 2019 by which time Joyce was gravely ill with sepsis and the onset of a heart attack. She was admitted to hospital where limited treatment options were then available due to the delay in seeking medical assistance. She died thereafter at 15.30 on 13th September 2019 at Epsom General Hospital, Epsom. Joyce's death was as a result of Natural Causes, contributed to by neglect. I adjourned consideration of whether to write a report for the prevention of future deaths for further evidence to be provided.
4	**CIRCUMSTANCES OF THE DEATH** i.) Joyce was a resident of Roseacre Care Home, Banstead. ii.) She was a frail, elderly person with diabetes, chronic arthritis which particularly affected her back, living in chronic pain, and she had chronic kidney disease, a potential kidney mass under investigation and high blood pressure, osteopenia. She was mobile sometimes requiring the assistance of a stick or a frame and she was largely capable of her own personal care but needed assistance with putting cream on her legs and taking her medications. iii.) Roseacre had an arrangement with a local GP surgery, Longcroft Clinic. The designated Doctor for the home and its sister home, Roseland, whose designated day for visiting was Wednesday morning. The Homes were free to contact the surgery on any other day of the week if any issues or concerns and on Mondays and Fridays this would be attended to by the designated Dr and on the other days by his colleagues. The Home staff were also advised if in any doubt to

contact OOH Drs, 111 or 999 as necessary.

iv.) The designsated doctor visited Joyce on 29th May 2019 as a welcome visit and saw her again for a minor infection of the skin of the legs on 28th August 2019 for which he prescribed a week's course of antibiotics. This issue appeared to resolve.

v.) Over the weekend of 7th and 8th September Joyce's family visited and Joyce seemed her usual self and the family had no concerns.

vi.) On night of Sunday the 8th September Joyce rang for assistance at 3.30am complaining of what might have been indigestion pains and she asked for a glass of water. She was not a regular sufferer of indigestion, nor was she on a prescription for antacids. At this time no further questions were asked of Joyce about her symptoms.

vii.) In the morning of Monday 9th September this had not resolved and she continued to complain of pain which again the staff considered was indigestion without further question of her symptoms. At approximately 11am Joyce vomited. She vomited at least once more, possibly twice, and the Head of Care asked the designated doctor who was visiting two other resisents to also look at Joyce.

viii.) The designated doctor checked Joyce over thoroughly. He found her to have signs of a mild viral illness, possibly stomach based, and that her chest was clear. He advised the home to put in place a number of safeguards: to monitor her blood sugar as vomiting with diabetes could be a serious concern and that if her blood sugar level reached 20 Joyce was to be sent to hospital; he also advised monitoring her fluid intake – particularly important in elderly people with viral illnesses and underlying kidney disorder and diabetes.

ix.) There is no record of fluid intake monitoring advice and this was not instituted by the care home staff. It is also basic practice when an elderly person is unwell and the care home have fluid charts for use in such circumstances.

x.) On Tuesday 10th September the minimal notes show no monitoring of blood sugar levels or of fluid intake save generally to say "drank

well". It is very hard to ascertain from these notes what Joyce's condition actually was. She is reported to "seem fine". She needed a painkiller in the night on 10th September. Whilst this was not unusual for Joyce who needed regular painkillers for her chronic back pain no questions appear to be asked of Joyce about her discomfort and assumptions are made about the source of her discomfort.

xi.) On Wednesday 11th September Joyce complained of feeling sick. Given that she was sick on Monday it is surprising that she was perfectly okay on Tuesday and ill again on Wednesday which again throws doubt on the recording of her on Tuesday. However, it is possible that her condition fluctuated. The sparse notes there are for Wednesday suggest that Joyce complained of feeling sick all day. The attitude to this by the care staff and management has been to minimize this symptom. I have been told that feeling sick and being sick are different. This attitude makes it clear to me that her symptom was dismissed as trivial and no investigation of it was taken. This is particularly concerning when this was the Dseginated Doctor's designated day for visiting so it would have been very easy for the doctor to be asked to check on Joyce. Given that she had been ill enough on Monday that the doctor was asked to see her, it is very difficult to understand why staff did not at least check with the doctor on Wednesday when Joyce was complaining of being unwell.

xii.) Joyce was described by her family who visited her on Wednesday afternoon as looking visibly unwell with a grey/blue colour, was unresponsive, struggling for breath, and non-responsive. This was a significant change in Joyce. Whilst the care home staff have noted Joyce was not feeling well there are no details at all and no investigation took place by Head of Care or anyone else into this. The family raised issues with the care staff including suggesting that Joyce potentially needed urgent immediate medical attention including an ambulance. The family say that the staff told her the doctor had been that day and that antibiotics were required. There is no record of the designated doctor seeing her on Wednesday or being asked to, there is no record of antibiotics. No one at the care home remembers the family raising an issue. There appears to be no place for such notes to be made. There is therefore no evidence from the care home on this point

xiii.) On Thursday 12th September 2019 again the notes reflect that Joyce was considered by the staff to be fine. It is noted she visited the toilet

twice in close succession in the morning. This may have been nothing but in the context of the week Joyce was having it was necessary to ask her some questions about this in case it was indicative of an issue. Again, the attitude has been to minimse any investigation into this change in behaviour. It was important enough to note but no basic further enquiries were made.

xiv.) The evidence of her being fine on Thursday is in contradiction with the family evidence that she was seen on Thursday by a family member who again considered her to be very unwell and described her as being green in colour. There is no evidence that this was raised with staff again but given it had been raised the day before and the family had been given the impression that action had been taken. It is also in contradiction with the GP notes of his examination and what he was told on morning of 13th. Recorded in his notes are "vomiting ongoing x 1 yday, again this morning"- that clearly suggests that Joyce vomited on Thursday 12th.

xv.) The notes then disclose that Joyce was very poorly overnight. It does not describe how or in what way. There is a note by the night staff that the designated doctor was due to see her in the morning. Care staff saw Joyce in the morning and one staff member was concerned and could tell Joyce was very unwell: she was pale and lacking energy and breathless. Her observations showed she was unwell. She required a wheelchair to move her which given that prior to this she had mobility with a frame was a marked change. There was a lack of urgency in the seeking of medical attention for Joyce. In spite of being very poorly in the night it was considered suitable to wait for the GP to attend which was not until 12.20pm.

xvi.) His description of his arrival was that on entering the building she was clearly and visibily so unwell that even without examination he was sure she needed to go to hospital. He asked for the ambulance to be called and he undertook an examination which confirmed his suspicion of how ill she was. He told me that he was shocked at the deterioration in her between Monday and Friday.

xvii.) Joyce was then conveyed to hospital by ambulance. She was

	admitted to hospital with the following history: 3 day history of shortness of breath, and a two day history of vomiting. Also in the GP notes are the words "Has deteriorated since last visit on Wednesday". xviii.) Joyce was found to have sepsis from a secondary pneumonia following her mild viral stomach illness and she was found to be in peri-arrest. She was profoundly and seriously unwell. By this stage the hospital doctors considered that there was very little they could do for her and provided her with antibiotics and oxygen but she continued to deteriorate quickly and she died at 15.30. xix.) Expert opinion of the nature of Joyce's two conditions (pneumonia and heart attack) was that these were unlikely to be sudden onset over night on Thursday and that she was likely exhibiting signs of being unwell several days before. The expert evidence was that she was likely showing those signs in at least the 48 hours before her death. He told me that there was some possibility that in the diabetic and elderly symptoms can manifest differently than in another cohort and that the symptoms can be harder to recognise. However, the expert evidence was that Joyce was likely unwell enough to invite investigation and that the index of suspicion for patients in this cohort (that is elderly, frail, diabetes, other comorbidities, on painkillers) should be low.
5	**<u>CORONER'S CONCERNS</u>** 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. There was a lack of continuous oversight, a lack of notes, a lack of review of those notes and no investigations at the Care Home. It has been

	underlined to me heavily throughout the proceedings that the care staff are not medically qualified. I accept that and would not expect them to be so in a residential care home setting. However, they had a duty of care for Joyce and that included keeping her under sufficient observation to allow for medical assistance to be called promptly as necessary. 2. Although the staff were aware of their duties if someone was ill they did not appear to have sufficient training or understanding of the signs of illness in the elderly which can be more subtle. 3. There was evidence of failure to ask Joyce simple questions to elicit whether concern was needed; trivialization of her symptoms by people who were not medically qualified to say that those symptoms were trivial; and a general lack of liaison with each other and overview such that in snapshot form it was possible to miss or to minimse the symptoms Joyce had over the course of a week and to make assumptions which then put Joyce at risk. 4. There was no recording of family concerns and no process in place to do so. 5. There were no accurate notes of when the designated doctor was to visit or who the doctor was asked to see. 6. The understanding and training about sepsis in elderly people was not adequate.
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. 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] 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	**Signed:** **J. Russell-Mitra** **Dated this 7th March 2022.**