IN THE WEST SUSSEX COUNTY
CORONER'S COURT

Before:

THE CORONER

Day 18
Monday 7 October 2013

INQUEST INTO THE DEATHS OF RESIDENTS
AT ORCHID VIEW NURSING HOME

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[Court resumed]

THE CORONER: Members of the family, sorry about the long delay, the 15 minutes that I had indicated, I think some of you were trying to get a coffee, and it's not the quickest queue in the restaurant there, so, before I begin my conclusion I discovered that, when I went back to the office that I had two pages stuck together, and I hadn't given the evidence in respect to Wilfred Gardner, and those of you who were present, will remember that his daughter came over from Australia to give her evidence. So, I'm just going to add the summary of the evidence in respect of Mr Gardner.

It was Lyndsey Ball who was the daughter of Wilfred Gardner and she said that her father was taken into hospital in December 2010 and that it was upon his release from hospital that he was discharged to Orchid View, and that was on 28 March 2011.

Mrs Ball came over to England in April 2011 and she went to the home and she was surprised to see how much her father had deteriorated since she last saw him. When visiting him she would take him outside, but what happened when she went to Orchid View, she always noticed that he was in bed. She noticed that his food and drink would be left in his room, for him to manage himself, which wasn't appropriate, she said, in his condition.

She noticed that Wilfred spilt a lot of food on his clothing, and on one occasion she found, when she visited him, that he had soiled himself. She said she had to chase the staff to get him to be washed and changed and get his bedding clean. She said that she never saw any medical care being administered to him and when she was asked about his medication she was told that the home had told her that they couldn't disclose to her any information about his medication.

Mrs Ball knew that he was ill, but she said that she had hoped that the care

home would give him the support he needed and at the very least making sure that he ate. Mrs Ball stated that she didn't liaise with any particular member of staff, and only ever saw a couple of staff there anyway.

And she said that it was whilst she was over from Australia that she went to see a relative of her husband, and whilst there was phoned by Orchid View to tell her that her father had been taken into hospital, and when she got to the hospital she found that he had died.

I am now going to deal with my conclusion in this case. I am going to start by saying, right at the beginning, it's clear to me that there were serious failings in the quality of care provided by Orchid View, and it is equally clear to me that this failing was on three levels, the corporate level, the managerial level and the individual professional practice.

The failings occurred across a wide gambit of issues, including a lack of respect for the dignity of residents, poor nutrition and hydration, mismanagement of medication, including the widespread indifference to the relief of pain, inadequate completion of medical records, and a lack of staff and staff of an appropriate mix of skills and experience.

This is a case where there was institutional abuse throughout the home, and it started, in my view, from a very early stage, and nobody seemed to do anything about it.

I find, from the evidence that this home was, from the top down, completely mismanaged and understaffed, and the home failed to provide a safe environment for the residents. Those who did nothing, or turned a blind eye should be ashamed. It's disgraceful that this home was allowed to be run in the way it did, and run for nearly two years. I really hope that those involved reflect on what happened at Orchid View and take the experience away with

them so that they can prevent it happening somewhere else.

This home was given a good rating by CQC, in January 2010. I question how could this be the case, and do wonder whether the inspection that took place at that time, was fit for purpose.

It was unfortunate that the home was then, not inspected for over a year, due in part to the restructuring of CQC. Despite the outcomes of the second report, the care home was allowed to continue failing and, in the words of a few witnesses, "Was getting worse for another four months."

It's a heart-breaking case. We all have parents who will probably need care during the latter part of their lives. We should have the confidence that when we place their care in the hands of others that we should be able to trust those involved.

Senior managers, involved with Orchid View, need to reflect upon the harm that they allowed to happen in this home. During the course of the evidence there was a fair amount of sloping shoulders, and what concerns me is that many of those involved are still working in similar roles within the industry.

Currently, there does not appear to be any restriction that can be imposed on those involved in the management chain where a home fails. CQC told us the only restriction is if they are the registered manager or nominated individual for the home. Sadly this means that there could be another Orchid View operating somewhere else.

This case would not have made its way into the public domain had it not been for the whistle-blower. The involvement of the whistle-blower meant that this was escalated to a formal police investigation. I have to commend Lisa Martin for the courage in speaking out. Had she not done so, then I really believe that what went on in Orchid View would have been swept under the carpet once the

home had closed.

This inquest raises many matters of public concern that need to be further investigated. However, I understand, albeit it's very late in the day, and this morning; but I understand that an expert, Nick Georgiou, a respected, independent expert, is going to carry out an independent Serious Case Review, and that's going to go across all of the agencies, including CQC.

It is on this basis that, at present, I do not propose to exercise my discretion to request a public inquiry, nor make any Schedule 5, Rule 7 reports, but I will say, I have a very keen interest in this case, and I will keep those matters under constant review.

Now turning to each individual case; firstly I am going to deal with the six cases of individuals who died after the home closed, but who had been resident during the last six months of the home being open.

As I indicated, it is my view that this home was operating in an unsafe way and residents were at risk. However, despite this being a pretty unpleasant place to be living in, the police investigations, and the inquest, did not find any specific incidents of neglect associated with these individuals.

Therefore, in respect of Barbara Wilkinson, who died on 27 December 2011, of acute chronic gastro-intestinal bleeding, I will record that she died from natural causes.

In respect of Brenda Mary Anderson, who died on 1 January 2012, from cardiac failure, I will record that she died from natural causes.

In respect of Ethel Menhennett, who died on 10 January 2012, from bronchopneumonia, I will record that she died from natural causes.

In respect of Winifred Maud Redhead, who died on 16 January 2012, of bronchopneumonia, I will record that she died from natural causes.

In respect of Ronald Kenward, who died on 27 January 2012, from bronchopneumonia and chronic airways disease, I will record that he died from natural causes.

In respect of Vera Doris Redmond, who died on 29 February 2012, from bronchopneumonia, I will record that she died from natural causes.

I now turn to the remaining 13 cases, where evidence has been given at this inquest, relating to the lack of care provided to these individuals. The evidence has been summarised in the safeguarding alerts, the health reviews and evidence given by individuals.

First of all I'm going to deal with Maisie Martin. Maisie Martin was a resident at Orchid View from 22 June 2010; she died on 5 June 2011. The medical cause of death was Carcinomatosis and cerebral accident.

If I can now address Hilary Bunn. From the evidence that I have heard, the care provided to your aunt, was suboptimal, in particular, but by no means limited to the unreported fall, resulting in the fractured hip, lack of provision of pain relief and the care given around her pressure sores. However, there is insufficient evidence before me to show that that suboptimal care was directly causative of her death, and therefore I will record that Maisie Martin died from natural causes.

I will now turn to Maureen Donaghey, who was a resident at Orchid View from 14 February 2010. She died on 24 July 2011. The cause of death was pulmonary thrombo-embolism. Mr Donaghey, from the evidence I have heard the care provided to your mother was suboptimal, in particular, but by no means limited to, the unexplained bruising and incidents relating to the provision of her medication.

However, there is insufficient evidence before me to show that this suboptimal

care was directly causative of her death, and therefore, in respect of Maureen Donaghey, I will record that she died from natural causes.

I now turn to Graham Miller, who was a resident at Orchid View from 16 November 2009, and he died on 15 May 2011. The cause of death was 1. Renal failure and 2. Dementia. Mr Miller. He's not here. From the evidence I have heard, the care provided to your father was suboptimal, in particular, but by no means limited to, the lack of management of his skin integrity and wounds his physical well- being.

However, there is insufficient evidence before me to show that this suboptimal care was directly causative of his death.

I now turn to Ellen Winifred Alice Bates, known as Alice, who was a resident of Orchid View from 7 April 2011; she died on 17 May 2011. The cause of death was metastatic oedema carcinoma. I think we might have Mr Bates here? Mr Bates, from the evidence I have heard, the care provided to your mother was suboptimal, in particular, but by no means limited to, the lack of nutrition and hydration leading to the weight loss, and the unaccounted bruising to her chest.

However, there is insufficient evidence before me to show that this suboptimal care was directly causative of her death, and therefore, I will record that she died from natural causes.

I will now deal with Percy Everett Bates, Alice's husband, who was resident at Orchid View from 7 April 2011 and he died on 14 May 2011. The cause of death was a urinary tract infection, and frailty of old age. Mr Bates, from the evidence I have heard, the care provided to your father was suboptimal, in particular, but by no means limited to the lack of nutrition and hydration leading to weight loss, and the unexplained fall in the shower.

However, there is insufficient evidence before me to show that this suboptimal care was directly causative of his death, and therefore, I will record that he died from natural causes.

I now move to Wilfred Gardner. Wilfred Gardner was a resident at Orchid View from 28 March 2011; he died on 1 May 2011. The medical cause of death was sepsis and renal failure, 1b UTI, and 2 Type 1 diabetes mellitus and chronic renal failure.

From the evidence I have heard the care provided to Mr Gardner was sub-optimal, in particular, but by no means limited to the failure to provide for his nutritional needs and failure to prevent Mr Gardner's necrotic wounds from becoming infected. As we know, he was hospitalised for two days and died eight days later.

I am satisfied that on the balance of probability that this neglect was linked to his death, and I propose to record that Mr Gardner died from natural causes attributed to by neglect.

We then turn to Bertram Jerome, who was a resident of Orchid View from 13 May 2011. He died on 21 December 2011. The medical cause of death was subdural haematoma with trauma. Mr Jerome, on the evidence I have heard the care provided to your father was suboptimal, in particular, but by no means limited to, the lack of proper management of his nutrition and hydration needs, the poor management of his medication, in particular in relation to his pain relief.

However, there is insufficient evidence to show that this sub-optimal care was directly causative of his death.

I then turn to John Robert Holmes. Mrs Mulvaney, John Holmes was resident at Orchid View on 4 July 2011 and he died on 7 September 2011. The medical

cause of death was bronchial pneumonia. Mrs Mulvaney, Mr Holmes, from the evidence I have heard, the care provided to your father was sub-optimal, in particular, but by no means limited to, the lack of proper management of his nutrition and hydration needs, and the management of his medication.

Having taken into account the specific evidence from Dr Ameen, the pathologist, I am satisfied that, on the balance of probabilities, that the lack of nutrition in this case did contribute, albeit we cannot say how much, although it is more than trivial, to his death. I therefore propose to record a narrative verdict that Mr Holmes died from natural causes, which was attributed to by neglect.

Jean Leatherbarrow. Jean was a resident of Orchid View from 18 April 2011, and she died on 11 February 2012. The medical cause of death was acute subdural haemorrhage. Mrs Newton, Mrs Akehurst, from the evidence that I have heard, the care provided to your mother was suboptimal, in particular, but by no means limited to, the lack of proper management of her nutritional needs, and weight loss, and the management of her medication.

However, there is insufficient evidence to show that this suboptimal care was directly causative of her death, this is due, in part, to the length of time that elapsed between her leaving Orchid View and her death.

Enid Mary Trodden. She was a resident of Orchid View from 19 April 2010; she died on 27 October 2011. The medical cause of death was 1(a) immobility and 1(b) Dementia and Parkinson's. Mrs Lincoln, from the evidence I have heard, the care provided to your mother was suboptimal, in particular, but by no means limited to, the management of her medication and management of her dehydration and weight loss. I am satisfied from the evidence that I have heard that this suboptimal care did, in fact, contribute to her death. I therefore

record that Enid Trodden died from natural causes, attributed to by neglect.

Margaret Tucker, resident of Orchid View from 26 March 2010, and she died on 27 July 2011. The medical cause of death was 1(a) cardiac failure and 1(b) mitral valve disease. Mrs Newman, Mr Tucker, from the evidence that I have heard, the care provided to your mother was suboptimal, in particular, but in no way limited to, her unexplained injury, the lack of management of her medication and pain relief.

I am satisfied, from the evidence that I have heard, that this suboptimal care did, in fact, contribute to her death, and I therefore record that Margaret Tucker died from natural causes, attributed to by neglect.

We then turn to Doris Fielding, resident of Orchid View from 1 June 2011, and she died on 25 December 2011. The medical cause of death was that she died from a UTI. Mrs Charatan, from the evidence that I have heard, the care provided to your mother was suboptimal, in particular, but in no way limited to, the lack of management of nutrition and hydration, the management of her medication and the management of her skin integrity.

I appreciate that as a result of this care, she was admitted to hospital from 26 September to 3 November. Thankfully there was an improvement in her health following this admission. And she did not return to Orchid View. She sadly died six weeks later from a UTI.

From the evidence I have heard therefore, it has not been possible to link the suboptimal care directly to her death, and I will record that she died from natural causes.

And finally if we could deal with Jean Halfpenny, Jean Halfpenny was a resident of Orchid View from September 2009, and she died on 5 May 2010. The medical causes of death were an intra-cerebral infarction and a pituitary

tumour.

Miss Halfpenny, Mrs Collins, from the evidence that I have heard, I am satisfied the care provided to your mother was suboptimal, in particular, but by no means there is my finding that there was a failure around the administration and monitoring of her Warfarin.

I found it as a matter of fact that she was overdosed on Warfarin whilst at Orchid View and the staff at the home fabricated the MAR sheets to cover this error up. The original MAR sheets were then shredded.

Dr Dent gave evidence that on the balance of probability that if the overdosing hadn't occurred and she had not had the trauma of going into hospital it was his view that she would not have died on that particular day, in that particular way.

Therefore, on the balance of probabilities, I am satisfied that there is a link between this and her death, and I therefore propose to record that Mrs Halfpenny died from natural causes, but attributed to by neglect.

Now, members of the family, I do appreciate that some of you will be disappointed that it was not possible to link the suboptimal care to the cause of death. As I indicated right at the beginning, the function of an inquest is limited, and for me to be able to find neglect in the verdict, it's got to be shown to be directly causative of the death, and that's the difficulty I have had in many of these cases.

But as I said, in respect of all of them, I am satisfied that there were serious failings in the quality of care given to your loved ones, and that lack of care did cause harm.

Members of the family that concludes the conclusions in this case, but before I close the inquest I'd like to express my thanks to all of the families here who

have shown throughout the hearing, the utmost dignity. It's been very difficult for you all, I appreciate, it's been five weeks and I know that many of you have given up a lot of your personal time to support this inquest process, so I do thank you.

I would also like to thank the witnesses who have come to give evidence; I know many have come back today to see the outcome of this inquest. As I said, we could not be here today if it hadn't been for the whistle-blower, and whatever thoughts you have in respect of the individual concerned, I would, as I say, commend her for coming forward to enable the facts in this case to be aired in this public way.

Can I thank Counsel, for once I can't see them, but can I thank you for your assistance throughout this process; it has been of utmost assistance to me. And can I thank Helen, my Coroner's officer and the police support team, who have assisted with this particular process.

So members of the family that just leaves me now to formally close the inquest, and as I said to you, I will continue to have a keen interest in how this matter now proceeds with the Serious Case Review and will ensure that further action is taken, if necessary, so thank you very much.

MR KORN: Madam, just before you rise, madam, two matters. Firstly thank you very much for your comment in your summary, and just before you delivered the individual verdicts that, in your view, the inquest raises a number of matters that need further investigation. And in a slight change of emphasis from when I addressed you before you started summing up, the question now crystalizes then is the right form for that investigation to take the SCR or public inquiry; and it is to that issue that those instructing me are going to be examining for the family.

The letter that you very kindly provided, from West Sussex County Council, raises two interesting points, but one is of immediate concern to the families, one is the one already touched upon by Mr Glasgow earlier, that it's not immediately clear that the local authority is going to be investigating itself, and that is something that will concern the families if that were the case.

And secondly, that whilst none of the families are focussing their attentions on blame, and accountability, it is of some concern that the framed reference of this inquiry is said to be specifically not to apportion blame. At some point the various members of the family expressed this thought to you throughout, and they do want to see somebody accountable for what happened to their loved ones.

Now, at the moment though all I'm saying is that the first thing those instructing me are going to do, is to find out more about when, and in what frame of reference, this SCR has been commissioned. I think I understand what scoping means; it's on Monday of next week that the SCR will sit to determine its own frames of reference, so we won't be pestering them until after Monday.

But madam, and you may have thought you'd seen the last of counsel – if it would be possible to have five minutes of your time in chambers, just before we all disappear, so that you can pass onto us what you do know about the SCR, to avoid letters being sent from Irwin Mitchell to you, via Helen, and then replies and a rather lengthy process, it may be that a few minutes with you will answer the question.

THE CORONER: Thank you.

MR KORN: Thank you very much. And the second thing madam is just to thank you, on behalf of the families, for your patience and hard work on behalf of their loved ones, and they very much appreciate the thoroughness with which you

have tackled this task. And personal thanks that you have allowed advocates unusual scope in the way that we've asked questions, we are all very, grateful for that and to thank Mrs Lawrence for her time [inaudible] on behalf of all of us.

THE CORONER: Thank you very much, just responding to the matter regarding the public inquiry, at this stage I will confirm that I will keep it under review. Thank you very much everybody.

[**The hearing was closed]**