H M Assistant Coroner for Gloucestershire
Caroline Saunders

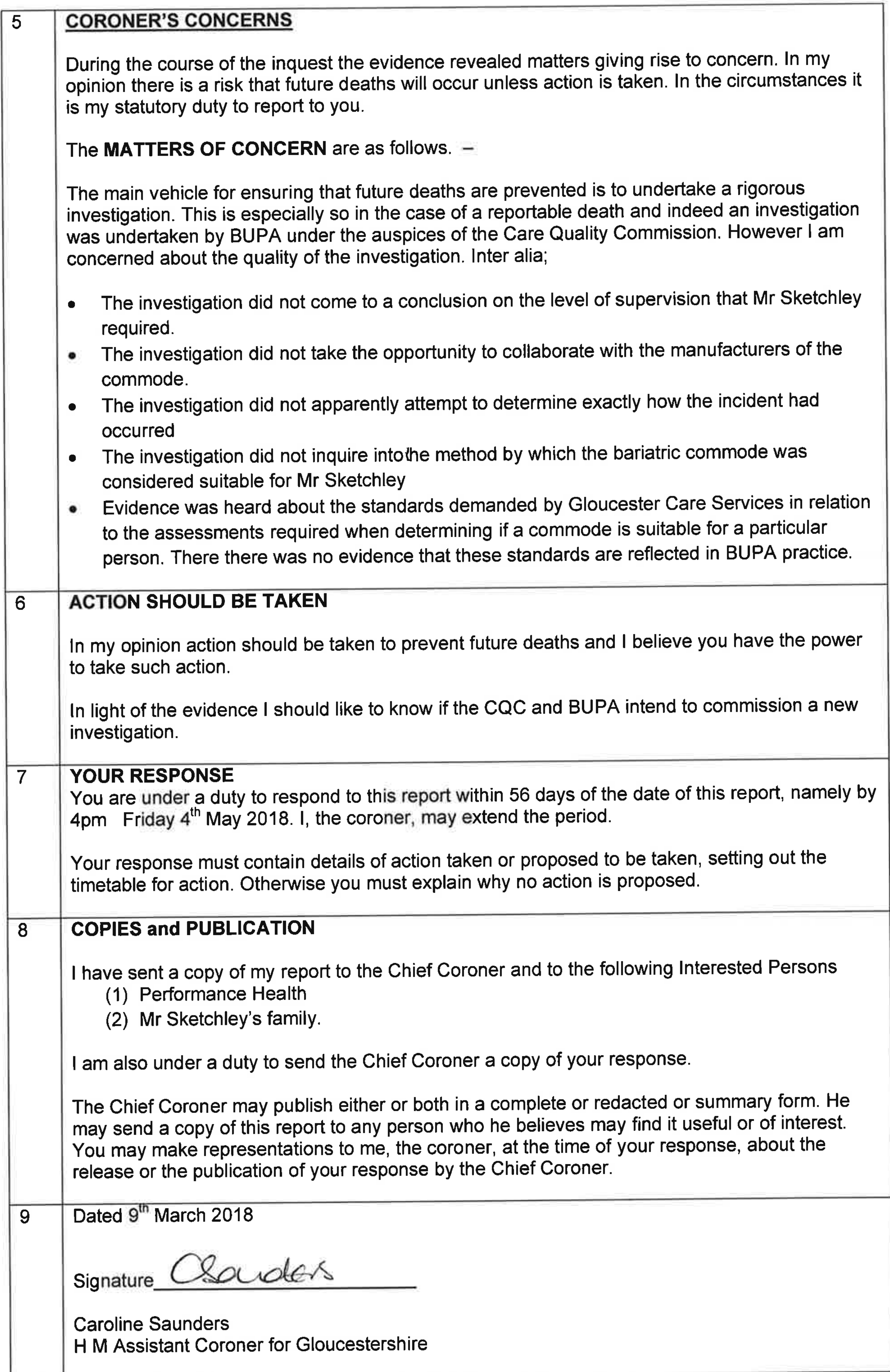
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **BUPA UK, Bridge House, Outwood Lane, Horsforth, Leeds, LS18 4UP**
1	**CORONER** I am Caroline Saunders, H M Assistant Coroner for Gloucestershire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 27th July 2017 I commenced an investigation into the death of David Anthony Sketchley. The investigation concluded at the end of the inquest on 28th February 2018. The conclusion of the inquest was a narrative conclusion. *The following factors contributed to and caused the death of David Anthony Sketchley:* 1) *Inadequate Supervision* a) *During incident an appropriate carer was absent during the incident* b) *Lack of clarity in care plan. His supervision needs were unclear, as were the definitions of supervision.* 2) *Suitability of commode* a) *There is insufficient to no evidence of David Anthony Sketchley's suitability for a bariatric commode in terms of documented risk assessment.* The medical cause of death was 1a) Sepsis and bronchopneumonia 1b) traumatic perianal laceration 2 Hypertensive heart disease and cerebro-vascular accident
4	**CIRCUMSTANCES OF THE DEATH** Mr Sketchley was a resident at Ashley House Nursing Home, in Cirencester, a residential facility run by BUPA. On 16th July 2017, Mr Sketchley was seated in a commode chair. He attempted to raise himself from the chair and in the process managed to dislodge the commode pan and flip the seat on the chair. The commode chair was a bariatric chair with a horse shoe design. This design means there is a gap at the front of the seat and it appears that on raising himself from the chair, one of Mr Sketchley's legs became lodged in the gap thus causing the pan to dislodge and the seat to flip up. Mr Sketchley's body then fell between the gap in the front of the chair and in so doing his anus was impaled on one of the supporting bars beneath the seat (no longer in situ). The injuries Mr Sketchley sustained caused his death the following day.

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. – At the time of the incident Mr Sketchley was to be supervised. The evidence that I heard was the main carer thought that whilst on the commode Mr Sketchley was to be supervised at all times. The care plan dictated that generally Mr Sketchley was to be supervised regularly. I heard no evidence that staff understood exactly what level of supervision was required. I heard from Demelza James that it is deemed acceptable to not observe / watch a resident who is being supervised but just to listen to them. I heard no evidence that Mr Sketchley's care plan stated this was a sufficient level of supervision, nor that there are any guidelines to assist staff when making decisions about the level of supervision a resident requires.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. In light of the evidence I should like to know what action if any BUPA has taken to review its practices in relation to the supervision of residents and whether consideration has been given to develop guidelines for staff in making decisions about frequency and intensity of supervision.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm Friday 4th May 2018. 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 (1) Performance Health (2) Care Quality Commission (3) Mr Sketchley' s family. 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 9th March 2018 Signature [signature] Caroline Saunders H M Assistant Coroner for Gloucestershire

Gloucestershire Coroner's Court, Corinium Avenue, Barnwood, Gloucester, GL4 3DJ
Tel 01452 305661 | Fax 01452 412618

H M Assistant Coroner for Gloucestershire
Caroline Saunders

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **i. BUPA, Bridge House, Outwood Lane, Horsforth, Leeds, LS18 4UP** **ii. CARE QUALITY COMMISSION, City Gate, Gallowgate, Newcastle upon Tyne NE1 4PA**
1	**CORONER** I am Caroline Saunders, H M Assistant Coroner for Gloucestershire.
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 the 27th July 2017 commenced an investigation into the death of David Anthony Sketchley. The investigation concluded at the end of the inquest on 28th February 2018. The conclusion of the inquest was a narrative conclusion. *The following factors contributed to and caused the death of David Anthony Sketchley:* *1) Inadequate Supervision* *a) During incident an appropriate carer was absent during the incident* *b) Lack of clarity in care plan. His supervision needs were unclear, as were the definitions of supervision.* *2) Suitability of commode* a) *There is insufficient to no evidence of David Anthony Sketchley's suitability for a bariatric commode in terms of documented risk assessment.* The medical cause of death was 1a) Sepsis and bronchopneumonia 1b) Traumatic perianal laceration 2 Hypertensive heart disease and cerebro-vascular accident
4	**CIRCUMSTANCES OF THE DEATH** Mr Sketchley was a resident at Ashley House Nursing Home, in Cirencester, a residential facility run by BUPA. On 16th July 2017, Mr Sketchley was seated in a commode chair. He attempted to raise himself from the chair and in the process managed to dislodge the commode pan and flip the seat on the chair. The commode chair was a bariatric chair with a horse shoe design. This design means there is a gap at the front of the seat and it appears that on raising himself from the chair, one of Mr Sketchley's legs became lodged in the gap thus causing the pan to dislodge and the seat to flip up. Mr Sketchley's body then fell between the gap in the front of the chair and in so doing his anus was impaled on one of the supporting bars beneath the seat (no longer in situ). The injuries Mr Sketchley sustained caused his death the following day.



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. –

The main vehicle for ensuring that future deaths are prevented is to undertake a rigorous investigation. This is especially so in the case of a reportable death and indeed an investigation was undertaken by BUPA under the auspices of the Care Quality Commission. However I am concerned about the quality of the investigation. Inter alia;

- The investigation did not come to a conclusion on the level of supervision that Mr Sketchley required.
- The investigation did not take the opportunity to collaborate with the manufacturers of the commode.
- The investigation did not apparently attempt to determine exactly how the incident had occurred
- The investigation did not inquire intothe method by which the bariatric commode was considered suitable for Mr Sketchley
- Evidence was heard about the standards demanded by Gloucester Care Services in relation to the assessments required when determining if a commode is suitable for a particular person. There there was no evidence that these standards are reflected in BUPA practice.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

In light of the evidence I should like to know if the CQC and BUPA intend to commission a new investigation.

7 **YOUR RESPONSE**

You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm Friday 4th May 2018. 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

(1) Performance Health
(2) Mr Sketchley's family.

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 9th March 2018

Signature______________

Caroline Saunders
H M Assistant Coroner for Gloucestershire

H M Assistant Coroner for Gloucestershire
Dr Simon Fox QC

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Medicines and Healthcare Products Regulations Authority, 151 Buckingham Palace Road, Belgravia, London SW1W 9SZ**
1	**CORONER** I am Caroline Saunders, H M Assistant Coroner for Gloucestershire.
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 the 27th July 2017 I commenced an investigation into the death of David Anthony Sketchley. The investigation concluded at the end of the inquest on 28th February 2018. The conclusion of the inquest was a narrative conclusion. The medical cause of death was: *The following factors contributed to and caused the death of David Anthony Sketchley:* *1) Inadequate Supervision* *a) During incident an appropriate carer was absent during the incident* *b) Lack of clarity in care plan. His supervision needs were unclear, as were the definitions of supervision.* *2) Suitability of commode* a) *There is insufficient to no evidence of David Anthony Sketchley's suitability for a bariatric commode in terms of documented risk assessment.* 1a) Sepsis and bronchopneumonia 1b) Traumatic perianal laceration 2 Hypertensive heart disease and cerebro-vascular accident
4	**CIRCUMSTANCES OF THE DEATH** Mr Sketchley was a resident at Ashley House Nursing Home, in Cirencester, a residential facility run by BUPA. On 16th July 2017, Mr Sketchley was seated in a commode chair. He attempted to raise himself from the chair and in the process managed to dislodge the commode pan and flip the seat on the chair. The commode chair was a bariatric chair with a horse shoe design. This design means there is a gap at the front of the seat and it appears that on raising himself from the chair, one of Mr Sketchley's legs became lodged in the gap thus causing the pan to dislodge and the seat to flip up. Mr Sketchley's body then fell between the gap in the front of the chair and in so doing his anus was impaled on one of the supporting bars beneath the seat (no longer in situ). The injuries Mr Sketchley sustained caused his death the following day. Ashley House immediately stopped using this design of bariatric commode.

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. – That the design of the chair contributed to the injuries that Mr Sketchley received. I heard evidence from Performance Health, the manufacturers of the commode, that the Medical Devices Agency has taken the decision to downgrade the commode into a category such that when a patient is damaged when using the commode, even if the injury proves fatal that there is no need for this to be reported to the MDA. Therefore no MDA investigation in relation to the product's safety has taken place. In addition the main vehicle by which any potential problems with products is brought to the attention of other users, is lost.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. In light of the evidence I should like to understand the rationale for downgrading the commode in the terms set out above, and following this incident whether that decision will be reviewed.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm Friday 4th May 2018. 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 (1) BUPA (2) Care Quality Commission (3) Mr Sketchley' s family. (4) Performance Health 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 9th March 2018 Signature________________________ Caroline Saunders H M Assistant Coroner for Gloucestershire

H M Assistant Coroner for Gloucestershire
Caroline Saunders

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Performance Health, Nunn Brook Road, Huthwaite, Sutton in Ashfield, Nottinghamshire NG17 2HU**
1	**CORONER** I am Caroline Saunders, H M Assistant Coroner for Gloucestershire.
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.
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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. – That the design of the chair contributed to the injuries that Mr Sketchley received. I heard evidence that the design of the chair has not been reviewed, in part because the exact mechanism of injury was not known until the inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. In light of the evidence I should like to know whether a review of the design of this commode will be undertaken.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm Friday 4th May 2018. 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 (1) BUPA (2) Care Quality Commission (3) Mr Sketchley' s family. 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 9th March 2018 Signature CSaunders Caroline Saunders H M Assistant Coroner for Gloucestershire