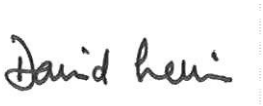
John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Registered Manager, Gwern Alyn House residential Home, 48 Percy Road, Wrexham, LL13 7EF
1	**CORONER** I am David Lewis, Assistant Coroner for North Wales (East and Central)
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 26th of November 2020 an investigation was opened into the death of Albert Rowlands (DOB 20.8.1920, DOD 25.11.2020), aged 100. The investigation concluded at the end of the inquest heard by me on Thursday 22 July 2021. The conclusion of the inquest was one of accidental death, with the medical cause of death being 1(a) Pneumonia; 1 (b) Fractured neck and hip (operated); II COPD, Frailty of old age and Hypertension.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Mr Rowlands' death are that he suffered serious injuries in an unwitnessed accidental fall on 16.11.20 at the residential care home where he lived. He was subsequently conveyed by ambulance to Wrexham Maelor Hospital where, despite appropriate treatment, he passed away on 25 November 2020. It was known to the care home that Mr Rowlands had a long history of recurrent falls, associated with an inclination for frequent unsupervised wandering. He was recognised as being a vulnerable resident. To help manage the risk he had been supplied with a Zimmer frame and a bedside pressure mat, and was to be checked upon every couple of hours during the night. At around 13:45 a Care Practitioner saw Mr Rowlands in the dining room, without his Zimmer frame, looking unsteady. She accompanied him back to his room for his own safety. On arrival she found food on the bed and floor, which she determined needed to be addressed. She proceeded to change his bedding and mop/dry the floor before helping Mr Rowlands into bed, after which she left him alone in his room. A short time later a Senior Care Practitioner heard noise coming from Mr Rowlands' room and went to investigate. The alarm which ought to have been triggered by the pressure mat had not sounded. She found him lying on the floor of bedroom in a pool of urine. It was noted that his pressure mat was not correctly positioned and that the bed has not been lowered to the correct position. The Care Practitioner said that when dealing with Mr Rowlands she had felt under pressure due to other responsibilities, explaining in statements that she 'felt pressured to hurry up', and had 'sorted everything as quickly as I could' before leaving Albert. Evidence concerning staffing levels was inconsistent, but it seems that at certain times during the day there might have been four care staff and one senior to look after up to 28 residents, spread across two floors (plus a communal lounge and separate dining area on the ground floor).

	Mr Rowlands had been moved to a ground floor flat due to his wandering and falls risk, but not to an en-suite room.
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. Despite the care home having identified the risks associated with Mr Rowlands wandering unsupervised and falling, the control measures put in place (including Zimmer frame use and the bedside pressure mat), these did not eliminate the risk. Mr Rowlands (on the occasion of this accident and at other times) was plainly able to get out of bed without his alarm sounding, and to move around without always using his Zimmer frame. I believe that care home should consider whether more can be done to ensure that falls risks measures are implemented consistently, as intended, and to identify additional steps that could be taken to reduce the risks to residents such as Mr Rowlands. 2. The indication that care staff felt pressured should be reflected upon, in the context of whether they are able to devote as much time to vulnerable residents as might be required. By inference, the errors made in respect of the mis-locating of the pressure mat and the incorrect position of the bed are likely to have occurred because the carer involved was rushing. The care home should consider whether its staffing levels are appropriate, both in this context and in terms of how quickly a member of staff might ordinarily be able to respond to a pressure mat alarm sounding. 3. Given that he was found in a pool of urine, it is reasonable to infer that Mr Rowlands' reason for getting out of bed was to use the toilet. The journey to the nearest toilet required him to walk through two heavy doors and along a corridor. This must have presented a risk to somebody with his background. Consideration should be given to whether residents generally are optimally located within the care home, having regard to their respective needs and risk profiles.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 20th of September 2021 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 Family of the Deceased and to the Chief Coroner. 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 26th July 2021

	 Signature Assistant Coroner for North Wales (East and Central)