REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) CEO - NHS England** **(2) CEO - Blackpool Teaching Hospitals NHS Foundation Trust** **(3) CEO - Lancashire County Council** **(4) Managing Director – Mobility 2000**
1	**CORONER** I am, Rachel Galloway, Assistant Coroner, for the Coroner Area of Lancashire & Blackburn with Darwen.
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 15th January 2018 an investigation was commenced into the death of Jean Williams, aged 80, born 24th August 1937. The investigation concluded at the end of a 5-day Inquest (without a Jury) on the 9th November 2020. The Medical Cause of Death was: *1a Hanging* My Conclusion at the inquest was: *Accident contributed to by neglect.*
4	**CIRCUMSTANCES OF THE DEATH** 1. Jean Williams was 80 years of age at the time of her death on the 19th November 2017. At the time of her death, Jean Williams was temporarily resident at Thornton House Care Home ("the Home") in Thornton-Cleveleys. At 8.27 am on the 19th November 2017, Jean Williams was found deceased by day care staff at the Home in her room (Room A10). She was found to be fully clothed, lying on top of her duvet and an unplugged bed sensor. Her head had become trapped between the side of her bed and the chest of drawers, with her neck resting upon the bar of the bed lever, causing her death. On the evidence, I found she would have become unconscious within a matter of seconds; her death was rapid. 2. The Bed Lever had been prescribed by the Occupational Therapy Team at the Blackpool Teaching Hospitals NHS Foundation Trust ("the Trust"). On the evidence, I found that it had been fitted to Jean Williams' bed (by a member of

	the Occupational Therapy Team at the Trust) on the 3rd November 2017. The Bed Lever had a strap riveted to its frame. However, the Lever was not secured to Jean Williams' bed with that strap. The purpose of the strap was to prevent the Bed Lever from becoming dislodged and moving away from the edge of the bed, causing a risk of entrapment. Despite this, the Trust training of the Occupational Therapy Team in 2017 was that the use of the strap was optional. 3. Jean Williams' death occurred at some time between the hours of 6.30 a.m. and 8.27 a.m. on the 19th November 2017. Her death occurred because the strap attached to the Bed Lever had not been used to secure the bed lever to the divan bed. Had it been so secured, she would not have died on the 19th November 2017.
5	**CORONER'S CONCERNS** During 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. During the inquest, evidence was heard that: The supplier of the Bed Lever (Mobility 2000), Occupational Therapy staff at the Trust and Lancashire County Council Staff (including Care Assistants) working at Thornton House now fit or adjust Bed Levers if – on assessment – there is identified to be a problem. This raised concerns due to the following: (a) Mobility 2000 and Lancashire County Council staff are fitting Bed Levers and/or adjusting Bed Levers in the absence of the patient (and therefore not taking into account important individual patient factors such as patient height, when fitting the Lever). (b) Lancashire County Council do not currently have in place a policy that any concerns/issues raised on their risk assessments of bed levers at the premises should be reported to the Occupational Therapy Team at the Trust. (c) The Occupational Therapy Team at the Trust, who are now correctly trained to fit and assess a patient for the use of the Bed Lever, are not – at present – routinely fitting the bed levers at Thornton House. In fact, there has been a miscommunication that Bed Levers are no longer to be used at Thornton House. Occupational Therapists prescribe bed levers due to the medical need of the patient and are now trained to fit them properly following full assessment of the patient. I am concerned that the above raises a risk of future deaths in that bed levers are being fitted in the absence of the patient and not by the fully trained experts who have prescribed them. In addition, the following matters in respect of Mobility 2000 specifically caused concern: (a) Mobility 2000 did and do continue to fit bed levers in the absence of the patient at various different locations (not just at Thornton House) (b) I found that Mobility 2000 did not routinely use the strap when fitting bed levers in 2017 and it is unclear whether staff now have training that they should always use a strap on a Divan bed (c) The evidence from the Director of Mobility 2000 was that no Bed Levers had been supplied without a strap (to his knowledge). It was clear on the evidence

	that Mobility 2000 had purchased Bed Levers without a strap from Drive Devilbiss Healthcare Limited ("Drive"), which should only be used with a specialist bed (and not a Divan bed, which always requires a strap). There is a risk that Mobility 2000 are supplying or fitting these bed levers (Model 130) without a strap to Divan beds. I have also addressed this report to NHS England, as it was unclear on the evidence whether there may be similar instances of not using straps for Bed Levers (on Divan Beds) by Occupational Therapy Teams at other NHS Trusts.
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 **14th January 2021**. I, the assistant 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) [redacted] (the son of Jean Williams) (2) Blackpool Teaching Hospital NHS Foundation Trust (3) Lancashire County Council (4) Mobility 2000 Limited (5) Mr [redacted] (6) Ms [redacted] (7) Ms [redacted] (8) Ms [redacted] (9) Drive Devilbiss Healthcare Limited 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 Assistant Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**Dated 16TH NOVEMBER 2020**
	Signed:  **Rachel Galloway** **HM Assistant Coroner** **Manchester West**