ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Care Inn Ltd and Crosfield House Ltd** **2. Care Inspectorate Wales** **3. NHS Wales**
1	**CORONER** I am Ian Boyes, Assistant Coroner, for the coroner area of South Wales 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** I concluded an inquest on 11th July 2019. The medical cause of death was 1a Complications of Ischaemic Heart Disease, 1b Femoral Artery Thrombosis, 1c Peripheral Vascular Disease, 2 Immobility. The Coronial Conclusion was natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Barbara Humphreys was admitted into Crosfield house on 29 July 2018. This followed concerns regarding her care at her home in London. The mission to Crosfield house was initially in an emergency respite care basis but this developed into permanent care. On 3 August 2018 it was decided by a registered nurse employed by the company that bed rails were required for this is Humphreys. No risk assessment regarding the safe use of bed rails was completed by the care home. On 2 September 2018 Mrs Humphreys was found to be on the edge of her bed with her back pressed against the bed rail which caused a red mark. On 6 September 2018 she was found at 1:15 PM with her legs between the bedrail mattress no bumpers in situ and a red mark was noticed on her right shin. On 7 September at 11 o'clock it was noted that she had got her legs trapped between her bed rails. On 28 October 2018 she was observed to have her right lower leg trapped between the bed rails in bed while sleeping. On 16 November 2018 her right foot was again trapped between the mattress and bed rail and the lower part of the calf had gone a blue/purple colour. The foot was firmly trapped and took two carers to free the foot. Request was made for her to see the general practitioner however the general practitioner on that occasion decided not to see Mrs Humphreys. On 17 November 2018 Mrs Humphreys again had her foot between the bed rails and mattress which cause slight mottling to foot. Later that day Mrs Humphreys was taken to Bronglais hospital in Aberystwyth whereupon she underwent an amputation of the lower right leg from above knee. Sadly Mrs Humphries passed away in hospital on 28 November 2018. Despite the occurrences with regards to the bed rails the pathologist was of the view that the medical cause of death was, despite initial appearances, as a result of a thrombosis above the levels of constriction/entrapment of her leg and as such was natural causes. In the care home Mrs Humphreys had been

	made subject to a DNAR order of which the family were unaware and had been described by the GP as being for palliative care only when in fact she was not.
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 evidence in the case revealed a number of issues relevant to the use of bed rails and training of staff. I note that Crosfield house Ltd have been written to by the health and safety executive in relation to matters which were within the remit of the health and safety executive. I understand that a recent inspection by Care Inspectorate Wales has shown dramatic improvement. Nonetheless the concerns are such that I feel it appropriate to bring certain matters to the attention of the wider view. 1. The first issue is directed to Crosfield house Ltd and Care Inn limited and Care Inspectorate Wales. It relates to the use of mattresses which are either not designed for use on particular beds or when used on particular beds are not constructed or designed to maintain a level when a patient is placed in the centre of said mattress. Upon placing of a patient in the centre of said mattress certain mattresses can fold at the edge and otherwise become displaced such that a patient's limbs will not be maintained within the mattress area. The correct mattress for the correct bed is considered de minimus in terms of a standard 2. The second issue is also directed to Crosfield house Ltd and Care Inn limited and requires adequate training to be provided to all employees in the homes operated by your respective companies. The training should include the selection, fitting, management and review of bed rails and accompanying bedding arrangements 3. The third issue is also directed to Crosfield house Ltd and Care Inn limited. The staff and care homes in general under your control should complete a full and frank risk assessment in relation to any and all issues with regards to bed rails. This should be conducted with the input and knowledge of a patient's family members, if they so wish and the risk assessment should be reviewed regularly. 4. The fourth issue is directed to Crosfield house Ltd and Care Inn limited. The company should produce and implement a full bed rail policy which is either group wide or relevant specifically to Crosfield house Ltd. This should detail how the company intends to ensure their employees are following the letter and spirit of the regulations. 5. The fifth issue is directed to Crosfield house Ltd and Care Inn limited which is there was evidence that the completion of care plans and best interests assessments was required to be fitted round other duties and as such may not be completed in a timely fashion. The group and the care home shall consider whether assigning a set or allotted period of time for a RGN to complete the care plan and assessment in the working day would help ensure that the care plan is most accurate and appropriately detailed. 6. The sixth issue is directed to care Inspectorate Wales and National Health Service Wales. They shall consider and if so appropriate, draft and implement a policy which requires a care home or care provider to inform the family and next of kin of events in which are medically trained professional has attended to or seen the patient particularly in cases where there is no or varying capacity. 7. The seventh issue is directed to National Health Service Wales who should consider and if so appropriate draft and implement a policy to ensure that families of those assigned to palliative care and/or made subject to DNAR orders are provided sufficient information about how that decision has been made, that they as a family have been fully involved in the decision-making process and upon what information it has been made such as the limits of patient confidentiality may allow in the circumstances.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 17th September 2019, 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 family who may find it useful or of interest. 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	**23rd July 2019** **SIGNED: (electronic signature)** **I D Boyes- Assistant Coroner**