REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Health and Safety Executive** Redgrave Court Merton Road Bootle Merseyside L20 7HS 2. [redacted]**, Department of Health and Social Care** House of Commons London SW1A 0AA [redacted] 3. **Care Quality Commission** 2 Redman Place London E20 1JQ [redacted]
1	**CORONER** I am Mrs Samantha Marsh, Senior Coroner, for the coroner area of Somerset
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 28th of December 2022 I commenced an investigation into the death of Evelyn Ann Burcham, aged 96. The investigation concluded at the end of the inquest on the 27th September 2023. The conclusion of the inquest was 'Accidental Death' with the medical cause of Mrs Burcham's death being given as: Ia) Head Injury
4	**CIRCUMSTANCES OF THE DEATH** Mrs Burcham had resided at Frethey house Nursing Home ("the Home") since May 2017. She had suffered a stroke in 2016 and her condition had

	progressively worsened due to dementia. Mrs Burcham was incapable of doing anything for herself and she relied on the staff at the Nursing Home to anticipate and meet her every need and provide her with full care, including; personal care, hoisting, transfer, nutrition etc. She also lacked capacity and could only communicate through incoherent mumbling and facial expressions, which the staff who knew her well at the home had learned to interpret. The Home is a residential and nursing home which, whilst accepting patients with dementia, is not a dementia specialist service. On the 14th of December 2022 the Home had organised a carol concert in the communal lounge as part of their Christmas celebrations. It was attended by residents and their families, staff and church volunteers. Mrs Burcham was brought to the lounge and hoisted into a standard riser-recliner chair. As she lacked any ability to support her own posture she was wedged in with pillows and the chair legs elevated by staff (via the remote control) to prevent her from slipping out. Carers then went to assist other residents to access the lounge ahead of the concert starting. The riser recliner chair that Mrs Burcham was in appeared to be a fairly standard design; an electric chair plugged in at the mains to enable the mechanism via a remote control, which is attached to the chair via a cord, with a side pocket for storage of the remote control whilst it is not in use. Whilst Mrs Burcham was in the riser-recliner chair unattended, another resident of the Home has accessed the remote control for the chair. This other resident had dementia which manifested itself in a compulsion to randomly fiddle. The other resident fiddled with the remote control buttons as they were accessible, unlocked and unsupervised and, without any intention or malice (or indeed any appreciation whatsoever of what she had done, because of her own cognitive impairment) managed to elevate the chair to its full rise position and tip Mrs Burcham onto the floor. Mrs Burcham had no power of speech to call for help, nor was she able to support her own weight or break her fall. She landed on her head and sustained a severe bleed on the brain, sadly dying of her injuries ten days later.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – I am concerned that these chairs are common place in care home settings where residents suffer from cognitive impairment. The risks of another resident with dementia accessing the controls of the riser-recliner chair(s) was not foreseen by the Home and so was not factored into any operative risk assessment at the time; hence no measures were in place to minimise the risk. There remains a real and immediate risk that those with a cognitive impairment that manifests itself in a compulsion to fiddle and/or press buttons, can create a risk of death to other residents in the same care facility or setting. If this particular care home group did not foresee the risk then it is likely that others have not foreseen it either.

	I was told at the Home had made enquiries with manufacturers of these standard riser-recliner chairs about the ability to 'lock' the remote control and/or find a safe was of storing it so that it is not accessible to anyone who does not have the authority, training or appropriate cognitive function to be able to use it safely. It would appear that a chair with a 'safe' remote cannot be purchased by the Home and there do not appear to be any regulatory or manufacturing standards (over and above manufacturing standards for consumers) that require these types of chairs to have this, or some alternative, safety feature that limits the use of the controls. I was told that the only way to render the remote 'safe' was to turn the power off at the mains, which in itself could create health and safety issues if the chair needed to be operated quickly.
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 the **26th December 2023.** I, the coroner, may extend the period and am conscious that the deadline falls on Boxing Day. I would appreciate an early request for an extension if a response cannot be provided before Christmas closures. 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: (i) the Chief Coroner (ii) Mrs Burcham's family I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	 **31st October 2023**