REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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<tr><td></td><td>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. The Home Office
2 Marsham St, London SW1P 4DF

2. Helen Whatley MP, MP for Department of Health and Social Care</td></tr>
<tr><td>1</td><td>CORONER

I am Mrs Marsh, Senior Coroner for the coroner area of Somerset.</td></tr>
<tr><td>2</td><td>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.</td></tr>
<tr><td>3</td><td>INVESTIGATION and INQUEST

On 9th August 2022 I commenced an investigation into the death of Barbara Jean Rymell, aged 91 ("Barbara").
The investigation concluded at the end of the inquest on the 21st of November 2023.
The conclusion of the inquest was death by Misadventure. The medical cause of death was recorded as:
Ia) mechanical obstruction of respiration
Ib) presumed fall downstairs
Ic) –
II) senile myocardial atrophy, dementia, general frailty.

I recorded in box 3 of the Record of Inquest that:
Barbara Jean RYMELL, aged 91, was left unattended on a mechanical stair lift at her care home (Ashley House Residential Home) on the evening of the Eighth of August 2022. Risk assessments identified that Barbara was not permitted to use the stair lift unaccompanied or unattended due to her physical and cognitive limitations. Whilst left unattended, Barbara has left the mechanical chair and proceeded to try and ascend the stairs. She has fallen causing her head to become wedged in between the chair seat and the stairs at an awkward angle, meaning it was not possible for care home staff to free her, or administer first aid due to her body position. Barbara's breathing was compromised as a result of her entrapment, and she was pronounced deceased on the arrival of the paramedics.</td></tr>
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4	**CIRCUMSTANCES OF THE DEATH**

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Barbara became a resident of Ashley House Residential Home in Langport ("Ashley House") on the 8th August 2022. She took up residency on discharge from hospital where she had had an inpatient stay as a result of a fall in the community.

On becoming a resident of Ashley House Barbara had a known diagnosis of dementia, which sometimes affected her memory. She was at a high risk of falling and had blurred vision. All in all, she was a relatively frail elderly woman with known risks around her mobility and she relied on others to keep her safe.

Barbara was the only resident with a bedroom on the first floor of Ashley House. This could only be accessed via the stairs (which Barbara was incapable of ascending or descending safely) or the mechanically operated stairlift (which Barbara was not permitted to use unattended or unsupervised.)

On the evening of the 8th of August 2022 two carers were on duty; neither of whom were native English speaking nationals; one was Romanian and the other was Indian.

I was told that in order to be able to work in the UK, those requiring a Visa (as the two carers on duty did) must prove that they can read, write, speak and understand English to at least Level B1…. [that they must demonstrate that they] can understand the main points of clear standard input on familiar matters regularly encountered in work". Applicants for a Visa must have passed a Secure English Language Test (SELT).

It transpired during the Inquest that one of the workers on the evening of the 8th August 2022 had never passed the SELT, so was not qualified or permitted to work in the UK.

At 19:27 one of the carers called 999 to request an ambulance. It was clear, on the evidence, that Barbara had been left unattended on the mechanical chair for around five minutes. This was clearly contrary to the rules and procedures of Ashley House. During those five minutes she has left the seat of the mechanically operated stairlift (possibly unfastening the seat belt) and proceeded to climb the stairs; which she was unable to safely, due to do physical limitations and her underlying cognitive impairment.

She has fallen on the stairs, falling downwards. There were no witnesses to this incident but Barbara has been found, having fallen awkwardly, landing with her head trapped under the chair for the mechanically operated stairlift. Care staff were unable to free her because of the positioning and angle at which she was entrapped within the mechanics.

On calling 999 (copies of both recordings were played at the Inquest) it was obvious that neither of the care staff were sufficiently proficient in English to be able to:

(i) Explain clearly the nature of the medical emergency. An internal audit by the ambulance service revealed that the call-handler had selected an incorrect pathway. The correct pathway that should have been selected was "entrapment" but at no time during the call did the carer give any information that would have indicated that this was the presenting

problem. The carer repeated used the word “blocked” which added no assistance, clarity of explanation of the events that were unfolding.

(ii) Understand the difference between “bleeding” and “breathing”. This made any meaningful triage of Barbara’s condition virtually impossible. The call handler followed the script to ask if the patient was conscious and breathing (i.e. to ascertain clinical emergency and determination of a priority response) but this assessment was severely hampered given the carer did not appear to know or understand the difference between bleeding and breathing.

(iii) Understand the difference between “alert” and “alive”, which presented all of the same problems as referred in in (ii) above.

Paramedics arrived on a category 2 response and, on arrival, it was clear that Barbara was beyond medical help. She was pronounced deceased at the scene.

5 **CORONER’S CONCERNS**

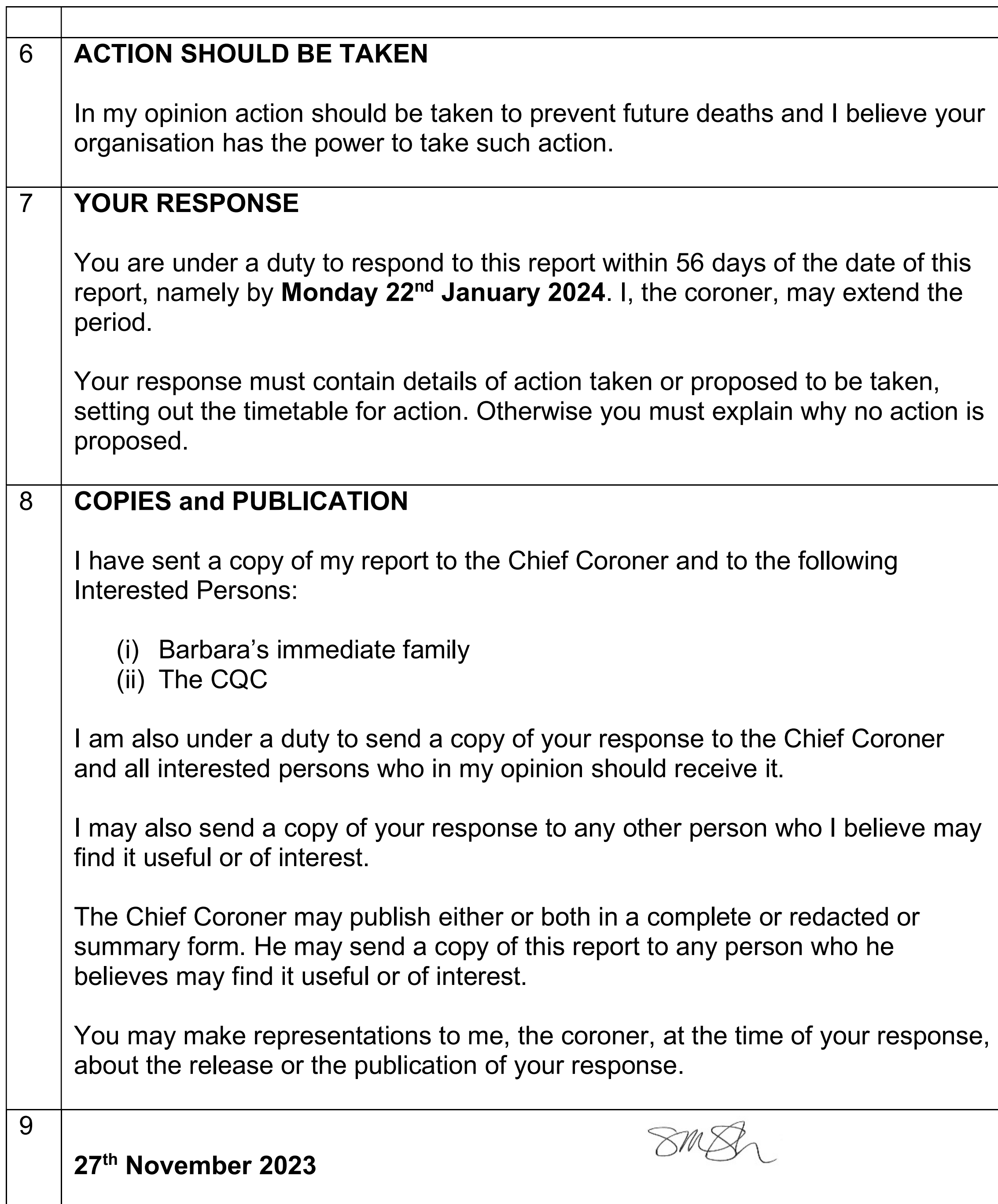
During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

I am concerned that those working with vulnerable people who are in a position of trust and responsibility must be able to demonstrate a sufficient proficiency in English to enable to summon appropriate emergency medical attention when needed. Vulnerable people, by very definition, are unable to often appreciate the need for help; take steps to keep themselves safe and/or summon help for themselves when they need it.

By being unable to speak the native language of England with any proficiency I am concerned that deaths will continue to arise where those who are young, disabled, suffering from a mental impairment or who are elderly and in need of urgent medical help will not have this summoned for them if those who are engaging with emergency professionals are unable to communicate effectively.

The Court looked at evidence of the B1 English test. Examples from the paper were as follows:
“I __________ that book last year” (options are bought, have bought, had bought)
“The town, ________ is very beautiful, has lots of parks” (options are which, where, what).
This level of comprehension is comparable to a KS2 curriculum being studied by Year 6 students sitting their SATS exam and appears to be wholly insufficient for those working in the direct care and protection of vulnerable people, as demonstrated in this case by carers who were alone (i.e. no English speaking members of staff on duty) being unable to explain to medical professionals the presenting condition of the patient.



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 **Monday 22nd January 2024**. 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: (i) Barbara’s immediate family (ii) The CQC 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	**27th November 2023**