IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Paul Rodney Batchelor
Regulation 28 Report – Action to Prevent Future Deaths

1	**THIS REPORT IS BEING SENT TO:** **In respect of first concern:** [redacted], Interim Chief Executive, Care Quality Commission [redacted] [redacted], Chief Executive Officer, Medicines and Healthcare Products Regulatory Agency [redacted] **In respect of second concern:** [redacted] Chairman The Red House (Ashtead) Limited
2	**CORONER** Ms Susan Ridge, H.M. Assistant Coroner for Surrey
3	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

4	**INQUEST** An inquest into Mr Batchelor's death was opened on 13 July 2023. The inquest heard evidence on 26 January, 19 June, 11 July 2024 and concluded on 14 August 2024. The medical cause of Mr Batchelor's death was: 1a. Bronchopneumonia and Positional Asphyxia With respect to where, when and how Mr Batchelor came by his death it was recorded at Box 3 of the Record of Inquest as follows: > Paul Rodney BATCHELOR died at his care home in Ashtead, Surrey. He had been assisted to bed by care home staff at around 2100 hours on 27 June 2023. Mr Batchelor slept in an extended profile bed which utilised a mattress extension to cover the gap between the standard mattress and the footboard. His bed was also fitted with bedrails. Later that same night he manoeuvred himself across the foot end of his bed, lying on the mattress extension. The bed did not have a deck in place supporting the mattress extension. As a result the mattress extension fell through the bed extension frame and Mr Batchelor became wedged in the gap which was then created between the standard mattress and the footboard. Although he cried for help for over an hour his cries were not responded to and he died of positional asphyxia and bronchopneumonia. He was found dead in that position shortly before 2330 hours on 27 June 2023 and his death was formally recorded by paramedics on 28 June 2023 at 00.01 hours that night. The inquest concluded with a narrative conclusion of 'Accident contributed to by neglect'

5	**CIRCUMSTANCES OF THE DEATH** During the course of the inquest the court heard that Mr Batchelor was a frail elderly man in a care home for respite care. He was provided with an Invacare Medley Ergo nursing care bed set up with an extended profile. To cover the gap between the end of the standard mattress and the extended foot end of the bed a mattress extension (or bolster) was fitted. The gap being approximately 20 cms wide. When he was put to bed on 27 June 2023 by care home staff, the mattress extension was in place. Shortly before 23:30 hours on 27 June 2023, Mr Batchelor was found lying unresponsive on his side across the foot end of the bed with his feet over the bedrails and part of his side and arm wedged in the gap between the standard mattress and the foot board. The mattress extension had fallen through the bed extension frame to the floor. Inquiries of the manufacturer of the bed, Invacare, indicated that the bed should have been fitted with an extension deck which would have supported the mattress extension (or bolster) and prevented it falling through the bedframe. This would have been part of the original mattress support extension kit. The court heard that the care home was unaware that the bed when extended required a deck to support the mattress extension. The bed had been used in this format for many years. There was no memory of a supporting deck ever being in place and when the mattress extension was inserted into the gap the standard mattress and the extension mattress appeared stable supporting each other. Unfortunately, under the pressure of Mr Batchelor's weight the mattress extension slipped through to the floor creating a gap into which he became wedged. The Court also heard that between 2205 and 2315 hours on the night of his death Mr Batchelor's numerous cries for help went unattended. For much of this time staff were undertaking their nighttime routine. However, the evidence revealed that a carer heard his cries at 2305 hours that night, but she did not open the door or go into his room as it was said she was frightened of him.

6	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are: <u>First Concern</u>: There may be a lack of awareness of the need to ensure adequate support for the mattress extension or bolster when using nursing care beds with an extension frame fitted. And that without adequate support there is a risk of death in that the mattress extension can fall through the bed frame creating a sufficient gap for a person to become wedged or stuck. The lack of awareness of the risk may be compounded because when the mattress extension is fitted into the gap between the standard mattress and the footboard it may appear as though the bolster is adequately supported. Further that over time and use mattress deck extensions or other supporting framework can become detached or lost from the bed Since this incident the court heard evidence that the care home and its sister care home have checked all existing extended profile beds and taken steps to ensure that they are fitted with the correct support. However, the coroner is concerned that users of nursing care beds with extensions may need to be made aware of the circumstances of this death to prevent other deaths in similar circumstances. <u>Second Concern:</u> The coroner notes that the care home has taken steps to ensure that any resident in distress and calling for help at night is heard. However, though the coroner has been shown minutes of briefings to care home staff conducted after Mr Batchelor's death emphasising the need to conduct checks of residents by going into a resident's room, she remains concerned that such briefings have not been formalised into care home policy and procedures. Nor do the minutes of those briefings explain what staff should do if they are frightened or concerned about entering a room on their own. There is the risk that rather than disturb a resident care home staff through, for example, fear or lack of time do not check a resident who may be in distress.

7	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
8	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
9	**COPIES** I have sent a copy of this report to the following: 1. Chief Coroner 2. Mr Batchelors family 3. Invacare Corporation 4. DHG (Talley Group Limited)
10	**Signed:** **Susan Ridge** **H.M Assistant Coroner for Surrey** **Dated 13 September 2024**