OFFICE OF THE
SENIOR CORONER
for the County of West Yorkshire
(Eastern District)

His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield WF1 2TS

Telephone: [redacted]
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REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** Lifeway Care Ltd, Unit 7, Suite 705, Ashbrooke Pary, Parkside Lane, Leeds LS11 5SF
1	**CORONER** I am Oliver Longstaff, Area Coroner for the Coroner area of West Yorkshire (Eastern District)
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 30/08/2022 I commenced an investigation into the death of Gloria Linton, aged 77. The investigation concluded at the end of the Inquest on 28/11/2024. The conclusion of the Inquest was a narrative conclusion, recording the cause of death as 1a) Pneumonia 1b) Rib fractures due to entrapment in a commode 2) Covid 19 infection, Cerebrovascular Disease, Ischaemic Heart Disease, Osteoporosis, Oropharyngeal Dysphagia (Clinical Diagnosis), and stating in summary that Gloria Linton died from the effects of medical complications arising from bilateral fractures of the posterior and lateral aspects of her ribs after she had become trapped in the aperture of a commode seat while being tended by carers.
4	**CIRCUMSTANCES OF THE DEATH** On 06/08/2022 carers had taken Gloria Linton in a wheeled commode into her wet room, where she had toileted and been showered while still seated in the commode. Carers assisted her to stand using manual handling techniques so that she could be dried and have moisturising and barrier creams applied to her. Gloria began to open her bowels again and carers attempted to sit her down on the commode, placing her on the commode seat at an angle such that her left leg passed through the gap at the front of the commode seat and her right leg followed, effectively trapping her in the commode seat's central aperture. She passed further down into the aperture, becoming trapped just below her chest. While trapped she sustained numerous osteoporotic fractures to the back and sides of both her ribcages, through either or both of her own efforts to free herself and the process of being extracted from the commode by the attending emergency services. The rib fractures were found at post mortem to have been a

	direct contributing cause of the pneumonia that was the immediate cause of Gloria's death in hospital on 23/08/2022.
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. – (1) The care plan in place for Gloria required her to be transferred between sitting and standing by two carers using a piece of equipment called a Rotanda. (2) Prior to the events of 06/08/2022 it had been noted and reported that carers were not routinely using the Rotanda, and it had been reiterated to carers by the relevant Community Health Trust that the Rotanda should be used, notwithstanding Gloria's reluctance. (3) On 06/08/2022 the carers did not use the Rotanda either to support Gloria to stand so she could be dried and her skin moisturised or to assist her to sit back on the commode when her bowels opened as she was being dried. (4) Had the Rotanda been used to assist Gloria to sit, it is unlikely that she would have been placed on the commode seat at an angle such that her legs could have passed through the opening at the front of the commode seat. (5) The carers were employed by Lifeway Care Ltd.
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 27/01/2024. 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: [redacted], Yorkshire Ambulance Service, Leeds Community Healthcare Trust. I have also sent it to the Care Quality Commission 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	Signed:  OLIVER LONGSTAFF Area Coroner West Yorkshire (E) Date: 2 December 2024