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Surrey Coroner’s bed safety concerns

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A frail, elderly man “cried for help for over an hour” before tragically dying after getting stuck in a gap between his care home bed extension, a Surrey coroner has found.

Paul Batchelor was found dead at The Red House, **Ashtead**, on 27 June 2023, after a mattress extension fell through his bed’s extension frame.

Assistant Coroner, **Susan Ridge**, raised concerns that Mr Bachelor’s “numerous cries for help” were not responded to and there is a “lack of awareness” about bed extensions which could put other lives at risk.

A spokesperson for the care home said the circumstances around Mr Batchelor’s death was “deeply distressing” and they “fully accept and respect” the assistant coroner’s findings.

Ms Ridge found that despite one carer hearing Mr Batchelor’s cries for help, she “did not open the door or go into his room as it was said she was frightened of him”. Even as he called out for help for over an hour, between 10:05pm-11:15pm, much of the staff were doing their night-time routine.

Mr Batchelor, who was under respite care, was put into bed around 9pm by care home staff. Later that night he had manoeuvred himself to the foot of the bed and was lying on the mattress extension.

But because there was no deck in place supporting the extension, Mr Batchelor fell through the bed extension frame and became wedged in the gap.

Ms Ridge also addressed her report to the governmental Medicines and Healthcare Products Regulatory Agency (MHRA) regarding a possible “lack of awareness” of the support needed for a mattress extension or bolster on extended beds.

She said: “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.”

A Red House spokesperson said: “We strive to provide the highest level of personal care and support to all our residents.” They added the company had addressed the concerns raised with equipment and staff protocols as a “matter of priority”.

The member of staff no longer works for the company, the spokesperson said, stating the care home has “ensured that the wider team understands how best to manage challenging or stressful situations”. They added: “We have underlined the importance of seeking support from others to sustain responsive and appropriate care, which is our highest priority.”

Dr Danielle Middleton, Deputy Director in Benefit/Risk Evaluation at MHRA, said she is reviewing the report carefully. The government agency has 56 days to respond to the coroner’s concerns.

Dr Middleton said the MHRA issued a National Patient Safety Alert, after reports of “adverse incidents” involving bed rails, medical beds, trolleys, bed rails, bed grab handles and lateral turning devices, warning of the risk of entrapment.”

The Alert requires staff receive device training suitable to their roles. Organisations are also required to have an up-to-date medical device management system in place, with regular servicing and maintenance of medical devices in line with the manufacturer’s instructions.

She added: “It also requires regular risk assessments for patients using bed rails or handles, including entrapment risks.”

The prevention of future deaths report, issued on September 13, has also been sent to the interim chief executive of the Care Quality Commission and chairman of The Red House (Ashtead) Limited.

The Red House Care Home, Ashtead. (Credit: Google Street View)

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