REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

Dorothea Jean Parr

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [redacted] Primary Care Medical Director at Cornwall Partnership, Foundation Trust
1	**CORONER** I am Dr Elizabeth Emma Carlyon, Senior Coroner for the coroner area of Cornwall and the Isles of Scilly
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** Dorothea Jean Parr died on 28th March 2016. An inquest was opened on 12th April 2016 and concluded with Inquest hearing on 20th December 2016. The conclusion of the inquest was accident and the medical cause of death was found to be 1a) Pneumonia, 1b) Left Neck of Femur Fracture (post op) 1c) Fall II) Ischaemic Heart Disease
4	**CIRCUMSTANCES OF THE DEATH** Dorothea Parr had an unwitnessed fall on the night of the 21st March 2016 at her home address, [redacted] She had slipped/fallen from a recently delivered electric riser-recliner chair while it had been raised to the upright/standing position by using the hand controls while she was sitting in it. She was assisted back into the chair by carers the next morning as there were no apparent injuries or pain from the fall. Bruising of the leg/thigh was noted on 24th March and she was admitted to the Royal Cornwall Hospital and diagnosed with a fractured neck of femur. She underwent a dynamic hip screw procedure on 26th March 2016 after being optimized for surgery. She deteriorated and despite medical support died on 28th March 2016 from pneumonia as a consequence of the fall. There was no malfunction with the electric armchair. Mrs Parr was very frail and was unable to transfer or stand without assistance.
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. – At the inquest the evidence showed that the electric armchair had been ordered by the Occupational Therapist and delivered by Tremorvah Industries (Mobility) at short/no notice to Mrs Parr's address on 21st March 2016. No notification was given to the son – who had requested to be present when it was delivered nor to the Occupational Therapist or Kerrier Home Care Ltd who provided the carers who would assist Mrs Parr in using the new chair. This meant there was limited or no opportunity for the family and carers or district nurses to be trained or for appropriate risk assessments to be carried out prior to the use of the new equipment or at the time of the first use. Mrs Parr was at high risk of falling. She was very frail and dependant on the carers for all her needs. She was not able to mobilise alone and required at least one carer to transfer. She would sit in the chair until the carers assisted her. The electric chair was provided on the day before she was found fallen. It appeared that Mrs Parr managed to use the controls to place the electric chair into the standing position while she was sitting in the chair resulting in her falling to the floor. In the days prior to the fall she had become more confused. The District Nurse Manger explained that it was the role of the District Nurses to carry out the Falls Risk Assessment for clients living in the Community at risk of falling. The District Nurses were very dependent on other agencies to inform them of falls or changes to the risk of falls e.g. the delivery of the electric chair or changes in presentation which increase the risk of falls e.g. confusion. In this case the District nurses were not informed of the fall on 21st March from the new electric chair and no requirement for this to be done and so there was a lost opportunity to provide input – which in this case could have been to deactivate the electric armchair while the carers were not present. Although there were informal procedures in place for district nurse notification, there were no formal protocols or procedures in place. There is a high mortality rate of elderly patients who fall and fracture their femur
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation have the power to take such action. The District Nurse, Occupational Therapist, Care Agency and family considered that risks could be addressed better and preventive measures put in place if a) There was a timed and planned delivery of medical equipment e.g. electric armchairs to ensure that the appropriate community agencies such as the Occupational therapist, carers and family <u>could</u> be present at the time of the delivery if necessary. This could ensure full training of use of the equipment and risk assessments to be carried out in structured way and with sufficient time to facilitate the use of the equipment for each patient. b) To review the process of carrying out falls risk assessments in the Community and formalise the method of notification of care agencies of concerns or changes in risk after fall or in patient presentation.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 23rd February 2017. 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]. I have also sent it to [redacted] (District Nurse Manager), [redacted] (Occupational Therapist) and [redacted] the Manager of Kerrier Home Care Ltd 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	**[DATE]** **[SIGNED BY CORONER]** **28.12.2016** Elizabeth Emma Carlyon