	REGULATION 28 REPORT ON ACTION TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Avenue House Nursing and Care Home** **2. Kettering General Hospital** **3. Northamptonshire Healthcare NHS Trust (Falls Clinic)** **4. Care Quality Commission**
1	**CORONER** I am Hassan Shah, Assistant Coroner for the coroner area of Northampton.
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 the 15/03/2017 I commenced an investigation into the death of Gladys Kathleen Rich. The investigation concluded at the end of an inquest on 28/02/2018. The conclusion of the inquest was accidental death.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Rich was referred by her GP to the Falls Prevention Service in July 2013. An appointment was made to see her at home on 13/08/2013 but this was subsequently cancelled by Mrs Rich's daughter because Mrs Rich had been admitted to hospital with a fall on 02/08/2013. The falls service did not seek to re-book the appointment or attempt to reach out to Mrs Rich in order to determine whether their input was still required. On 28/07/2016, Mrs Rich sustained a fall, fracturing her right greater trochanter. Around 9 weeks later, on 07/10/2016, Mrs Rich moved into Avenue House Nursing and Care Home. The home undertook a pre-assessment but none of the witnesses were able to confirm its outcome. It was not known if any of the previous history including the recent fall had been considered. It was not known if Mrs Rich had been identified as being at risk of falls. The care home's policy was to wait for 3 falls before making a referral to the falls prevention service. However, the Falls Prevention Service only require there to have been one fall within the past 12 months before they will accept a referral. Mrs Rich suffered falls on the 8/10/2016, 13/10/2016 and 8/11/2016. The care home then sent a referral on 10/11/2016 to the Falls Prevention Service. The Falls Prevention Service then sent a 12 page assessment document to the care home which included guidance on how to reduce the risk of falls. Page 4 of

	the document which relates to cognitive impairment suggests possible options as follows: 1. Instigate more frequent checks on residents [there was no evidence that the care home changed the supervision regime from 2 to 1 hourly, save in relation to the immediate aftermath of 2 falls]. 2. Move resident's rooms nearer to care station [the care home stated there were no such rooms available] 3. Check for infections [the care home only undertakes general observations monthly and were not able to say how regularly Mrs Rich was checked. Infections are only checked when symptoms present]. 4. Consider use of chair/bed sensor mats [it was established at the inquest that bed sensor mats were perhaps the most appropriate for Mrs Rich however none were available at the care home]. 5. consider review by community psychiatric nurse [the care home was not able to confirm if this had been considered]. The falls risk action plan and its covering letter both specify that if further input is required, the action plan must be sent by *fax* to the falls service. Instead, the care home retuned the form by post and it was not received by the Falls Prevention Service. On 9/12/2016, the Falls Prevention Service wrote to the care home stating that they had not received a falls risk action plan and on that basis it was assumed the service was no longer required and the patient would be discharged. It was again stated that if further input is required, the falls action plan should be sent by fax. The care home did not respond to this letter and did not re-submit the falls action plan. During this period, Mrs Rich suffered further falls, more specifically on 21/11/16, 27/11/16, 10/12/16, 24/12/16 and 28/12/16. Despite this, the care home made no further referrals to the Falls Prevention Service. Mrs Rich suffered 2 falls of 28/12/16. The first was at 7.15am. Mrs Rich was taken to hospital. Her GCS was 14/15. Neurological examination was clear. Other tests were in the normal ranges except for slightly increased inflammatory markers for which antibiotics were prescribed. The doctor in A&E at Kettering General Hospital consulted the frailty team who flagged that Mrs Rich was "prone to falls". Despite this, following a consultation with Mrs Rich and her daughter and in light of the fact that Mrs Rich had returned to her baseline, she was discharged back to the care home, without a referral to the Falls Prevention Service. Before 10pm on 28/12/2016, Mrs Rich suffered a further fall which led to a traumatic subdural and sub arachnoid haemorrhage plus an acute skull fracture. It was those injuries that led to Mrs Rich's death on 3/03/2017.

	The Falls Prevention Service confirmed that they are a county wide service but only employ 6 people. Although there is County Council strategic implementation group, no entity exists which has an overarching responsibility for ensuring that GPs, care homes and hospitals are fulfilling their falls risks prevention obligations. The Falls Prevention Service do not currently have the resources to do follow ups. Following a post mortem, the medical cause of death was: 1a) Chest infection 1b) Left subdural haemorrhage and small left subarachnoid haemorrhage 1c) Fall 2. Rectal cancer with liver metastases
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. – 1. In relation to Avenue House Nursing and Care Home. a) Failure to identify Mrs Rich as a falls risk during a pre-assessment process, despite the fact that she had sustained a fall requiring hospitalisation 9 months before. The pre-assessment check may not therefore be sufficiently robust. b) The policy of waiting for 3 falls before making a referral seems to be arbitrary and also at odds with the Fall Prevention Service requirement of 1 fall within a 12 month period before a referral will be accepted. c) Once a referral was made, and a falls risk action plan was received the advice within does not appear to have been properly considered or actioned. Furthermore, the action plan was returned to the Falls Prevention Service by post rather than the required method of facsimile. Although the care home was notified that the Falls Prevention Service had not received the completed action plan, it was not resubmitted. Despite Mrs Rich then suffering a series of further falls, no new referrals were made to the Falls Prevention Service. d) The care home may not have some of the equipment that they require for patients such as Mrs Rich e.g. a bed sensor mat. 2. In relation to the Falls Prevention Service. a) Despite Mrs Rich having been referred to the Falls Prevention Service by her GP and the service being notified of a fall related hospitalisation in August 2016, the onus was placed on the patient and her family to make a further appointment. In the absence of any further contact, the service assumes that their input is no longer required. As is clear in the case of Mrs Rich, the prevention service was very much still required. Again, when the service was contacted in November 2016 the failure to receive a form or a response to the subsequent letter again led to an automatic assumption that input was no longer required despite the fact that this was the second referral to have been made in relation to Mrs Rich. It was explained in

	evidence that the reason the service cannot be more proactive is because they are inadequately resourced. 3. There does not seem to be any mechanism for ensuring that Falls Prevention Service input is in fact delivered when it is required and that a patient is only ever discharged when it is clear that the underlying symptoms causing the falls are resolved or that measures have been put in place to mitigate the falls risk.
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **10th July 2018**. 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] **(daughter).** Similarly, you are 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.
9	*H Shah* – ***Mr H Shah – Assistant Coroner*** **14th May 2018**