NHS
Cornwall Partnership
NHS Foundation Trust

[redacted]
Carew House
Suite 6
Beacon Technology Park
Dunmere Road
Bodmin PL31 2QN

Tel: 01208 834613
Email: [redacted]

6th April 2017

Dr Emma Carlyon
Senior Coroner for Cornwall and the Isles of Scilly

By Email only

cornwallcoroner@cornwall.gov.uk

Dear Dr Carlyon

Regulation 28 Report to Prevent Future Deaths following the inquest touching the death of Dorothea Parr

I refer to your Regulation 28 Report following the inquest of Dorethea Parr which has been addressed to [redacted] of Cornwall Partnership NHS Foundation Trust ("The Trust").

As you are aware, the Trust acquired Adult Community Services from Peninsula Community Health as of 1st April 2016.

You will have already seen the letter from [redacted] dated 20th February 2017 which also informs you that [redacted] joined the Trust following the transfer of the services after April 2016 to the Trust and has not been employed by Peninsula Community Health.

You request that the Trust take certain steps to prevent future deaths and that our organisation has the power to take such action. I am grateful to you for bringing these matters to my attention and enabling us to review and address these matters accordingly in relation to the services as they will be provided in the future.

You describe how Dorothea Parr had an unwitnessed fall at her home address on the night of 21st March 2016. She sustained a fractured femur from slipping or falling from an electric recliner riser chair by using the hand controls whilst she was sitting in it. She went on to have hospital treatment and surgery following her fracture but unfortunately she deteriorated and died from pneumonia after the fall. The fall occurred when it appears Dorothea operated an electric chair on her own which had been ordered for her use.

Following your discussion with professionals employed by Peninsula Community Health at the inquest, you have brought to our attention the risks which you feel could be addressed better and preventative measures put in place if the following is addressed:

a) There was timed and planned delivery of medical equipment e.g electric armchairs to ensure that appropriate community agencies such as occupational therapists, carers and family could be present at the time of the delivery if necessary. This could ensure full training on the use of the equipment and risk assessments are facilitated

b) To review the process of carrying out falls risk assessments in the communities and formalise the method of notification of care agencies of concerns or changes in the risk after fall or in patient's presentation.

In respect of a)

I am not able to express a view around the circumstances or facts leading up to this incident as it did not involve the Trust in any way and also involves the responsibilities of other organisations.

We do agree that timing of delivery is important and it appears that there was recognition that timing was important in relation to the specific facts in this case. We are unable to comment further upon that as it would be the responsibility of that organisation to investigate the incident and decide their own actions. The Trust does not propose to take any further steps in this respect

In respect of b)

Falls and fractures are a major cause of disability and mortality for older people. The prevalence of falls is high in the UK with 1 in 3 people aged over 65 and 1 in 2 people over the age of 85 falling each year. In Cornwall this equates to 36,000 falls per year. Women have a lifetime risk of a fractured hip of 12% and men 5%, and 14,000 people die per year in the UK as a result of a hip fracture (NSF / DoH 2001). In 2007, 750 people in Cornwall suffered a fractured hip (Public Health, 2007), and over 4000 attended A&E at RCH due to a fall (Margison, Falls Audit 2007).

The prevention and management of falls and injuries is currently high profile within the government's health strategy. The National Service Framework for Older People Standard Six (DoH, 2001) emphasises that all those who have fallen should be assessed and action taken to prevent further and more serious falls. The NICE (2004) Clinical Guidelines (21) on falls management add that older people who present for medical attention because of a fall, or report recurrent falls in the past year, or demonstrate abnormalities of gait and/or balance, should be offered a multi-factorial falls assessment. Recent national audits (2006 and 2007) of Falls and Bone Health by the Royal College of Physicians show that the local organisation of falls interventions is good, but recent data suggests that the majority of patients who have fallen, or who at are at risk of falling, are not being identified or accessing services. The „Our health, Our care, Our say" White Paper (2006) indicated the need for good local access to services, which includes falls services that are predominantly required by older people.

The Trust has committed to reducing the incidence of slips, trips and falls by 10% per year from 2008 to 2010 (Keeping people safe in our care, 2007). It also acknowledges the need to reduce health inequalities by improving access to care, helping to keep people fit and well and encouraging self-management and prevention rather than crisis driven care (Healthy Futures, 2007).

Standards for Better Health state that NICE clinical and public health guidance should be disseminated and implemented at all levels through a robust framework. The implementation of this policy will ensure that NICE guidance and NSF standards are being followed throughout the county for the management of falls.

Falls are often multi-factorial in origin and by undertaking a collaborative multidisciplinary approach, the risk of falling can be reduced. The falls risk assessment tools within this policy are evidence based and designed to assess patients at risk from a fall, support the reduction of risk of falling within the home and community environment and act as a marker for individual patients with regard to preventable causes. The appropriate management of falls is of the utmost importance because of its effect on the person's physical and psychological health.

The Trust has a policy which is specifically designed to deal with slips trips and falls in the community and since the Trust acquired the services previously provided by Peninsula Community Health, this policy has been embedded into the current service provided, as of 1st April 2016.

The policy requires staff to;

- Complete a risk assessment for patients who have fallen or who are at risk of falling.
- Where appropriate, a falls care plan and risk assessment are to be completed.
- Complete an incident report when a patient falls in their presence and ensuring lessons are learnt from investigations into previous falls and preventative actions are implemented and shared with team members.

The Trust also intends to employ a Trusts Falls lead on complex cases. The Falls Lead will chair the Trust Falls group which is intended to reduce the number of harm caused by falls and following a Serious Incident relating to a fall and the Falls Lead will investigate the incident make recommendations and develop and action plan. The Falls Lead will provide specialist clinical advice to the service areas where falls management is an issue

The Trust is also part of the NHS South West Patient Safety Improvement Programme which the Falls Lead will be attending and leads on falls work streams which includes raising awareness and sharing best practice with staff and other organisations.

The Trust does not intend to take any further action in this respect.

The Trust is saddened by the death of Dorethea Parr and extends its condolences to the family. Thank you for bringing these matters to the Trust's attention.

Yours sincerely

Phil Confue
Chief Executive