M. E. Voisin
Her Majesty's Senior Coroner
Area of Avon

8 August 2022 REF: 21890

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, University Hospitals Bristol and Weston NHS Foundation Trust ('UHBW')** **2. Head of Clinical Governance, UHBW**
1	**CORONER** I am Robert Sowersby, Assistant Coroner for the **Area of Avon**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 20 January 2021 an investigation commenced into the death of Mr Gerwyn John REES, aged 77. The investigation concluded at the end of the inquest on 3 August 2022. The medical cause of death was: 1a) Frailty and hip fracture 2) Delirium The narrative conclusion of the inquest was as follows: Mr Gerwyn Rees was elderly and frail, and at a high risk of sustaining serious injury from falling, when he was admitted to the Bristol Royal Infirmary on 28 November 2020. The staff looking after him in hospital did not take adequate steps to prevent him from falling, and he fell over on 29 November 2020, sustaining a fractured hip. He underwent surgery, but his condition continued to deteriorate over time, and in January 2021 he was discharged to Westin Care Home in Whitchurch for palliative care: he sadly died there on 17 January 2021, as a result of both general frailty and the hip injury sustained in hospital.

[redacted]
The Coroner's Court, Old Weston Road, Flax Bourton, BS48 1UL

4	**CIRCUMSTANCES OF THE DEATH**
	
	Giving a litte more detail, the circumstances of the death were that:
	• Mr REES was 77 years old and was in poor general health
	• He had a pre-existing brain injury, frontal lobe damage, a history of alcohol misuse and a significant psychiatric history
	• He experienced episodes of confusion and had memory problems
	• He mobilised at home with a stick or with a frame, or with assistance
	• Before the admission during which he broke his hip, Mr REES had a recent *previous* admission (from October to 25 November 2020), during which he had been investigated for gallbladder problems – an admission that he had not been expected to survive
	• I note from the RCA report that Mr REES had experienced an inpatient fall (at Callington Road Hospital) immediately prior to that admission, and further inpatient falls (at the BRI) during it
	• Mr REES had been discharged home from that earlier admission on 25 November 2020
	• While he was at home he appears to have had a number of falls over the ensuing days, and on 28 November 2020 (just three days after his discharge) he and his partner called 999
	• When the ambulance attended, the paramedics determined that Mr REES had postural hypotension (which meant he was often dizzy or lightheaded when he stood up); they were also concerned that he may have a heart condition, and were worried that he appeared not to be looking after himself
	• The paramedics took Mr REES to the BRI, where he was admitted the same day
	• The following day (29 November 2020) Mr REES had his falls risk assessed on Ward A413
	• That assessment was carried out by a Nursing Assistant, and then signed off by a Registered Nurse
	• At that time falls risk assessments were performed in line with the BRI's then-current Enhanced Care Observation and Meaningful Observation Policy ('the ECO Policy')
	• In my judgment, when his falls risk was assessed on 29 November 2020 Mr REES clearly and unarguably represented a high falls risk – there was a significant risk that he would fall, and a very significant risk that if he did fall, then he might sustain serious injury
	• To reiterate, at the time of that assessment Mr REES was:
	  ○ 77 years old
	  ○ Frail and appeared not to be looking after himself
	  ○ Mobilised with a stick or a frame, or with help, when he was at home
	  ○ Had fallen at least once, and possibly more than once, in the last 3-4 days
	  ○ Had fallen more than once during his last (recent) inpatient stay at the BRI
	  ○ Had a known brain injury (which both made him particularly vulnerable if he did fall, and also contributed to episodes of confusion and memory loss)
	  ○ Had been admitted with identified postural hypotension, which created an obvious falls risk.
	• Notwithstanding those obvious (and significant) risk indicators, Mr REES was assessed as requiring Level 2 Enhanced Care Observations: I note from looking at the relevant table in Appendix A of the then-in-force ECO Policy that this equates to a "low risk"
	• According to the text accompanying "ECO level 2", that level of observations is to be used when:

	*"The patient displays occasional unsafe behaviour (**which is not expected to result in serious harm**) or is at avoidable risk **of mild levels of harm**."* (Emphasis in bold added.) • The wording in this part of the table contains two distinct elements: the first relates to the likelihood of a fall taking place, the second relates to the likely seriousness of the outcome if a fall does happen • It appears self-evident to me that a frail 77-year old with a pre-existing brain injury is at risk of really serious harm if s/he falls over in hospital, and therefore that ECO level two could not in any way be an appropriate categorisation for someone in Mr REES's position, irrespective of whether he could properly be said to exhibit only occasional unsafe behaviour • Mr REES had his first inpatient fall later that same day – at around 12.30pm – although he did not sustain any serious injury at that time • He was then transferred to ward A515 • I was told in live evidence that Mr REES's falls risk had been reassessed after his first inpatient fall, and that he was moved to A515 as an "ECO level 3" patient, although that evidence was not supported by the contemporaneous medical records, or indeed by much of the written evidence that was submitted to me in the course of my investigation • Shortly after moving to Ward A515 Mr REES was left unattended by the Nursing Assistant who was supposed to be keeping an eye on him (she had gone to tell the Nurse in Charge that she thought he needed to be observed more closely); Mr REES tried to stand up to follow her out of the room, suffered his second inpatient fall of the day, and fractured his hip (an injury which later made a significant contribution to his death) • Although Mr REES underwent successful surgery, he never recovered fully from this injury, and he later died as a result of both his frailty and the fracture.
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 and in the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – • I find it very difficult to see how Mr REES could properly have been allocated to level 2 ECO observations ("low risk") at the time of his initial falls risk assessment on 29 November 2020 • However, notwithstanding that initial concern on my part, I am more concerned by the apparent absence of learning following Mr REES's death • The Trust's Root Cause Analysis ('RCA') investigation/report (co-authored by [redacted] a Matron / Senior Nurse) does not identify any issue or concern in respect of that initial allocation to ECO level 2 • Further – during the inquest – when I questioned the nurse who had approved the initial "Level 2" allocation on Ward A413 [redacted] she initially maintained that ECO Level 2 was appropriate for Mr REES at that time, before later conceding to me that he should have been allocated to Level 3 observations from the outset and that ECO Level 2 was not an appropriate categorisation for him at the time of his initial falls risk assessment • When I then questioned [redacted] (RCA co-author) about this same point, she too initially gave evidence that ECO Level 2 was a reasonable categorisation for Mr REES during the initial falls risk assessment, applying

	"*clinical judgment*" (albeit that she later accepted – I think – that it had not been an appropriate categorisation at that time) • I struggle to see how, as a senior nurse with responsibility for investigating an incident such as this and disseminating learning as a result of it, Nurse [redacted] can have suggested to me that ECO 2 was ever appropriate for Mr REES • The lack of criticism of Mr REES's initial risk allocation to ECO level 2 in the RCA report, coupled with these aspects of the live evidence of Nurse [redacted] and Matron [redacted] (see above) suggest to me that there was a lack of investigative rigour in the RCA reporting process, and/or that the ECO Policy was (and is) not properly understood by the staff involved in authoring the RCA, or in implementing the policy • Whilst it is relatively commonplace to see circumstances in which policies or standard operating procedures have not been properly understood or implemented on a ward, in real time, it is more concerning still to see circumstances such as these; in which even <u>after</u> the Trust's investigation and learning process have been completed there does not appear to be an appreciation of where mistakes have been made: this of course means that there has been a missed opportunity to learn from the death in question • For completeness, I do not think that I am wrong in my interpretation of the ECO Policy, but if I am, and if – following that policy properly – a patient with a background such as Mr REES <u>could</u> properly be described as at "low risk" and requiring only the protection that is afforded by ECO level 2, then I would be very concerned that the policy itself was not fit for purpose, or safe. 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.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 26 September 2022. 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 – the family of the deceased. 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	08/08/2022 Signature  Robert Sowersby Assistant Coroner **Area of Avon**