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

4 October 2022 REF: 24431

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive, North Bristol NHS Trust** **2. Head of Clinical Governance / Clinical Governance Lead, North Bristol NHS Trust**
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 13 September 2021 an investigation commenced into the death of Mr George Michael ELLIOTT, aged 81. The investigation concluded at the end of the inquest on 20 September 2022. The medical cause of death was: 1a) Traumatic brain injury 1b) Fall in hospital 2) Coronary artery disease The conclusion was that this was an accidental death, and the brief circumstances of the death were recorded as follows: On 4 September 2021 George Michael Elliott was an inpatient at Southmead Hospital, receiving investigation and treatment for an underlying cardiac condition, when he fell, sustaining a serious brain injury. Unfortunately his condition deteriorated some days later, and on 9 September 2021 he died in hospital as a result of the injury sustained in

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	the fall.
4	**CIRCUMSTANCES OF THE DEATH** At the time of his death Mr ELLIOTT was in hospital for investigation / treatment of an underlying cardiac condition. His underlying cardiac condition was treatable, but he suffered a fatal brain injury when he had an inpatient fall. Mr ELLIOTT had been admitted to Southmead Hospital on 29 August 2021. On 31 August 2021, while he was on the Acute Medical Unit, Mr ELLIOTT's falls risk was assessed by a member of the nursing staff, who completed online documentation using the Trust's "Lorenzo" system. That online documentation included a list of risk factors that had to be considered, the very first of which was whether the patient was aged 65 or over. To reiterate, Mr ELLIOTT was 81 years old at the time (a fact that was recorded on the Lorenzo system). The nurse recorded that Mr ELLIOTT had no risk factors (in respect of his risk of falls), despite his age. The risk assessment was not only in error, but the error was obvious (and on an objectively verifiable basis – not simply on a subjective assessment of how the patient presented). On 1 September 2021 Mr ELLIOTT was transferred to Cardiology ward 27a. In the early hours of 4 September 2021 he fell while trying to use the en-suite bathroom in his room, suffering a serious head injury which ultimately proved fatal. There was uncontentious evidence that Mr ELLIOTT's underlying cardiac condition was treatable, and that if not for his fall (and head injury), he would have survived the inpatient admission and could have received treatment for his heart while in the community. Mr ELLIOTT's brain injury led to a deterioration in his condition on 7 September, and he sadly died on 9 September 2021.
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. – My concerns are about the quality (or otherwise) of the Patient Safety Investigation ("PSI") which took place after Mr ELLIOTT's death. In Mr ELLIOTT's case the investigation (and accompanying report) overlooked obvious failings in his care. As a result important learning opportunities (and therefore important opportunities to improve patient safety in the future) were also missed.

	I am concerned that if this investigation (and report) is in any way representative of the quality and rigour of such investigations within the Trust, then the Trust may be missing vital opportunities to learn from its mistakes, and to make its patients (now and in the future) safer as a result of that learning. To give a little more detail: • The stated remit of the Patient Safety Investigation was to "*review the care episode… [and] to understand the events and identify opportunities to learn and to improve patient safety*" (see page 4 of the resulting report) • Given that this was a case where a patient suffered a fatal injury as the result of an inpatient fall, one of the first and most obvious points to investigate would have been the adequacy (or otherwise) of his falls risk assessment/s, and the extent of the nursing staff's compliance with any relevant Trust protocols / procedures • Notwithstanding that background, the PSI report failed to identify the (very obvious) fact that although a falls risk assessment had been performed, it had not been performed properly • There were also numerous *other* failings in the approach that had been taken to the assessment of Mr ELLIOT's falls risk, and/or the way that risk had been managed while he was an inpatient, but none of these were identified by the PSI / present in the report. • For example: - Para.6.13 of the Trust's then-current Falls Prevention Policy stipulates that Mr ELLIOTT's family should have been made aware of the outcome of his falls risk assessment. That did not happen, but the fact that it did not happen is not mentioned in the PSI report. - There is no indication that Mr ELLIOTT's falls risk was ever re-assessed (after 30 August 2021). According to the Trust's policy it should have been reassessed after he moved to the Cardiology ward, and again after his fall on 4 September, but no such reassessment took place, and the PSI report makes no mention of these oversights/omissions. - *After* Mr ELLIOTT's fall on 4 September, he continues to be described as at "low risk" of falls in the Daily Intentional Rounding documentation within his medical records. This is an alarming error, but one which has been overlooked entirely by the PSI report. • I asked Nurse [redacted] (one of the PSI-report authors, who gave evidence at the inquest) about the fact that none of these errors had been identified in the report and she had no explanation for why that was the case. As stated above, if PSI reports overlook clear / obvious failings, then learning opportunities are missed, patient safety is compromised, and there is a risk of future deaths. 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 29 November 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	04/10/2022 Signature Robert Sowersby Assistant Coroner **Area of Avon**

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