	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] **Chief Executive** **The Great Western Hospital** **Marlborough Road** **Swindon** **SN3 6BB** **Ms. Victoria Atkins MP** **Secretary of State for Health and Social Care** **Department of Health and Social Care** **39 Victoria Street** **London** **SW1H 0EU**
	CORONER I am David Ridley, Senior Coroner for Wiltshire and Swindon
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 the 13th February 2023 I commenced an investigation into the death of **Raymond Lionel Eggleton** and I opened an Inquest into his death on the same date. On the 14th November 2023 I concluded Ray's Inquest. I found the medical cause of death was as follows: 1a. Aspiration Pneumonia 1b. Dysphagia 1c. Hospital Acquired Delirium and Immobility due to Osteoporotic Right Fractured Neck of Femur (Operated 19/01/2023) and Acute On-Chronic Subdural Haemorrhage and Subarachnoid Haemorrhage following a Fall on Ward II. Falls due to Orthostatic Hypotension and Frailty of Old Age By way of a conclusion, I recorded not only the short form conclusion of Accident but also a Narrative Conclusion to explain when, where and how (by what means Ray came by his death). That Narrative Conclusion was as follows: - "Raymond died on the afternoon of 25 January 2023 at the Great Western Hospital in Swindon having developed an aspiration pneumonia attributable to swallowing issues (dysphagia), having developed hospital acquired delirium and immobility following a fall on the Linnet Acute Medical Unit during the early hours on 18 January 2023. As a result of the fall Raymond sustained an osteoporotic right fractured neck of femur (repaired 19 January 2023) and an acute on chronic subdural haemorrhage and subarachnoid haemorrhage. Raymond was admitted to hospital the day before with a history of recent falls attributable to orthostatic hypotension and was frail by virtue of his age. The falls risk assessment, prior to the fall on the ward, did not accurately take into account this history and as a consequence there was no assessment in respect of his additional care needs which more likely than not should have resulted in 1:1 care which

	probably would have avoided the severity of the injury by managing the fall when he needed to urinate or avoided him having to get out of bed in the first place.
4	**CIRCUMSTANCES OF THE DEATH** Having considered the evidence, I found the following facts in relation to the circumstances of Ray's death. Ray arrived late evening on the 16th January 2023 at the Emergency Department of the Great Western Hospital in Swindon. He had a history of 3 falls in the previous few days which following an examination was considered to be attributable to a condition called postural hypotension. This condition results in a sudden drop of blood pressure when somebody stands up and can cause dizziness even temporary unconsciousness. The treating clinicians view, in respect of which I agreed, was that the postural hypotension and general frailty likely caused Ray's falls noted over the previous few days. Ray was admitted the following day onto the Linnett Acute Medical Unit (LAMU) and a CT scan undertaken revealed evidence of chronic subdural haematomas, indicative of previous head trauma more likely than not attributable to earlier falls, not necessarily those falls in the last few days. In keeping with the hospital's falls policy, following his arrival on LAMU, Charge Nurse [redacted], who was starting the night shift, carried out a falls risk assessment amongst other assessments. Relying on information that was passed to him verbally at the shift handover before 8 o'clock that evening, he was however only told and therefore recorded as part of that falls risk assessment that Ray had had 1 fall in the last 12 months. Whilst recognising that there was a risk of a fall the assessment did not trigger any of the higher levels of monitoring over and above 1 hourly care rounding such as ensuring that Ray was within line of sight or more importantly was within arm's reach of a care worker. Whilst the plan was for hourly care rounding I noted that no such checks were made on Ray from 20:50 on 17th January 2023 until just after midnight on 18th January 2023, although it was not material in my view to the events that followed but was indicative as regards the working pressures faced by nursing staff on that shift. At 00:45 on 18th January 2023, Nurse [redacted] was called by another patient in the same bay as Ray and saw him stood next to his bed passing urine into a bottle. She recalls the night light was on and she could see him clearly. She observed him suddenly falling to the right not putting his hands out to break his fall and he fell hitting his head on the chair leg as he collapsed to the floor. Due to the postural hypotension Ray was being given IV fluids and this equipment was connected to his arm. I was not of the view that the equipment contributed to the fall and found as a fact that the fall more likely than not was attributable to Ray's postural hypotension. As a consequence of the fall, Ray was found to have suffered head trauma and in addition had fractured his right neck of femur in respect of which it was noted more likely than not it was an osteoporotic fracture. The fracture was repaired the following day on the 19th January 2023, however, Ray as a result of immobility and trauma sustained deteriorated and he began to develop swallowing issues. He also became generally more confused and ultimately, he developed an aspiration pneumonia from which sadly he died in The Great Western Hospital on the 25th January 2023. During the Inquest hearing I heard live evidence from Charge Nurse [redacted] who came across as a conscientious and caring Nurse. That having been said I did ask probing questions of Charge Nurse [redacted] as regards the discrepancy between Ray's pre-admission history and what was actually recorded as part of the falls risk assessment. By way of background, I was told that LAMU consisted of a ward with 36 beds. Back in January 2023 those beds were occupied by elderly patients. I was told following the arrival of a new Chief Nurse there had been improvements in relation to staffing levels and at the time of Ray's fall Charge Nurse [redacted] told me that there was 1 Senior Nursing Sister in charge, 5 Registered Nurses of which he was one, 4 Health Care Assistants and 2 enhanced Care Workers. There were no shortages in terms of their allotted numbers. Charge Nurse [redacted] was assigned 8 patients of which Ray was one of those patients and they were split between 2 bays on the ward. As previously stated, Ray's bed was not in direct eyesight of the nursing station. When asked why Charge Nurse [redacted] did not check the medical records where there were at least 4 entries referring to a number of previous

falls and postural hypotension, Charge Nurse [redacted] indicated that he relied on the verbal handover and that due to the volume of work he did not check either the electronic or paper records when completing the falls risk assessment. Initially when I challenged Charge Nurse [redacted] as to whether or not Ray would have been a candidate for 1:1 supervision/arm's length supervision the response was that Ray would have had to have had a fall on ward before that would have been considered. I rejected that argument as of course in this particular instance it would have made no difference here and sometimes it only takes a single fall to be causative in relation to an individual's death. My view and my finding was that the previous falls history and the presence of postural hypotension made Ray a prime candidate for arm's length supervision and had that been in place then more likely than not his injuries as a result of the fall would have been avoided and given that his intention at the time was to pass urine, the need for him to get out of bed at all more likely than not could have been avoided.

I asked all the witnesses who gave live evidence in relation to the challenges as regards getting 1:1 supervision and I noted in particular that the answers were consistent that it was very difficult to secure 1:1 supervision during a night shift. There was no pool of people available. I also noted the comments from [redacted] a senior member of the nursing team, as regards the dynamic changes that can affect LAMU over a very short period of time in terms of the acuity of patients on the ward. LAMU is an assessment ward and therefore its patients are ultimately either transferred to another ward or other hospital or discharged into the community such that the patient constitution on the ward can change quite dramatically during a shift. From being Senior Coroner for a number of years now I am acutely aware that in dealing with elderly patients it not only presents challenges in relation to addressing physical needs but often the elderly have additional mental health issues that only add to the level of the challenge to care for them. By that I mean conditions such as dementia, depression and Alzheimer's and as a consequence I was told whilst on paper the ward may appear to be adequately staffed, the reality is that does not necessarily translate, as I was of the view here, as was the case on the evening of the 17th and the morning of the 18th of January 2023, that there were not enough staff to meet the needs of the patients all of whom were vulnerable and to ensure that they were appropriately safeguarded. The inability to carry out hourly intentional rounding in relation to Ray combined with the evidence from Charge Nurse [redacted] was clear evidence to me of the extreme pressure that the nursing team faced in managing the needs of 36 patients on that shift.

5 **CORONER'S CONCERNS**

Falls in the hospital environment do happen and I am not saying that all can be avoided. That having been said what I have noted of late when dealing with these cases is an increase in the instances where as a result of my investigation, in relation to cases that I have been directly involved in, that I am making findings that more likely than not the falls could have been prevented and the injuries that were causative in relation to that individuals death, avoided.

Ray was a 96 year old gentleman who would have died had it not been for the fall at some point in the future. That may have been in a matter of weeks, months or even a few years but had it not been for the fall on the night of the 17/18th January 2023 he would not have died as he did, in the circumstances that he did, on the 25th January 2023.

During the course of the Inquest, I also heard evidence from Sister Jones and in addition to the challenge of getting the staffing levels commensurate to the patients needs and safeguarding patients there does appear to be an issue that causes me a concern as regards the ability to dynamically respond to a need for enhanced supervision especially entering into night shifts. Sister Jones when questioned was open and extremely candid in her answer that at those times nursing staff could not always support those additional needs in the short term because of the challenge to get additional personnel at short notice in circumstances where the nursing team were under pressure due to the complexities and demands of patient's needs. There is in my view no flexibility and resilience within the system to dynamically adapt and respond to changing patients enhanced needs exacerbated by the fact that especially during the winter months these beds are mainly occupied by the elderly. It is easier during day shifts to respond but there clearly appears to be an issue especially going into night shifts.

There were 2 issues here, firstly the initial falls risk assessment on LAMU which was not undertaken taking advantage of all available information which in my view led to an incorrect assessment of Ray's supervision needs. His fall was observed by another member of the

	nursing staff and therefore my view was that only arm's length supervision would have avoided the fall and that there were sufficient indicators to warrant this prior to the event occurring. The failure here in relation to the initial assessment was down to the volume of work and not in my view laziness or anything of that nature on the part of nursing staff. Flowing from the first issue a further issue relates to the resilience and the ability to respond dynamically with changing patients on the ward so as to ensure that vulnerable patients with a high degree of risk of falling, like Ray, are properly safeguarded. [redacted] in her evidence talked about an ongoing programme, the Enhanced Care Toolkit Framework, which I acknowledge is work in progress, in respect of which not only the family but also I am interested in hearing what steps the Trust intends to take to mitigate against a risk of further incidents occurring such as the fall that Ray had on the night of 17th/18th of January. This report is also being sent to The Secretary of State for the Department of Health and Social Care and the reason I have sent this to The Secretary of State is to highlight the issue and my concerns. Often when Regulation 28 Reports are submitted responses often come back from Government Departments as regards the increase in the amount of money that they are injecting into that particular public service. Coroners cannot make recommendations but as we advance in time into yet another winter period, which will undoubtedly be challenging for frontline NHS personnel, combined with an ever-increasing elderly population whose care needs both physical and mental are more complicated and demanding, it is essential that when these vulnerable people come into the care of the state, that they are effectively safeguarded. I cannot see this winter being much different from last winter and at the moment and my concern is that potentially it could be worse. Whilst the focus of this report relates to a hospital environment, the challenges created by an increasing elderly population in terms of NHS and social care response affects those in the community as well. I do not believe that there is an easy fix for these issues when resources and budgets are stretched. The problem here undoubtedly is multi factorial but any solution here is one in respect of which the Government undoubtedly has a crucial role to play, and I hope The Secretary of State understands why she is a recipient to this Regulation 28 Report.

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 12th January 2024. 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 Person, Family of Mr Eggleton, Chief Executive at Salisbury District Hospital, Care Quality Commission 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.	Dated 17th November 2023 Signature [signature] David Ridley, Senior Coroner for Wiltshire & Swindon