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

27/10/2023 [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health** **2. Bristol Ambulance Emergency Medical Services** **3. [redacted], Friend of the deceased** **4. Royal United Hospitals Bath NHS Foundation Trust** **5. South Western Ambulance Service NHS Foundation Trust** **6. Chief Coroner**
1	**CORONER** I am **Debbie Rookes**, Assistant Coroner for the Coroner 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 12th December 2022 an investigation was commenced into the death of Gerald Roy Cruse. The investigation concluded at the end of the inquest on 27 November 2023. The conclusion of the inquest was: **Accident** The cause of death was recorded as: 1a) Pneumonia 1b) Rib fractures, haemopneumothorax 2) Osteoporosis, frailty, ischaemic heart disease, transient ischaemic attack
4	**CIRCUMSTANCES OF THE DEATH** On 23 November 2022, Gerald Cruse was taken to the Royal United Hospitals Bath by ambulance following a fall at home. He was assessed as being suitable for the Ambulance Cohort Area, which was run by Bristol Ambulance Emergency Medical Services. Mr Cruse was placed in a bed once one became available. He needed to use the toilet so a member of ambulance staff lowered the bed rails and sat Mr

	Cruse on the edge of the bed before then going to get a wheelchair to transport him to the toilets. Mr Cruse then stood up and fell. He sustained a significant chest injury, including multiple rib fractures, a haemopneumothorax and surgical emphysema. He was cared for on a surgical ward in accordance with the admissions pathway, with input from the older persons medical team. Despite active treatment, his condition deteriorated and he developed pneumonia. Mr Cruse died on 7 December 2022at the Royal United Hospitals Bath.
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. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – **Secretary of State for Health** (1) That over 75% of patients receiving hospital care are 65 and over. There is a conflict and tension between where within the hospital those patients should be receiving their care. A proportion of these patients require admission to a surgical ward due to the elements of their care which require surgical oversight and management, for example, analgesia through an epidural, insertion of a chest drain. However, this group of patients have multiple co-morbidities and complexities due to their age, which would be better managed by a medical team specialising in care of the elderly. Whilst medical teams can review patients, their limited resources mean it may not be as quickly as it needs to be, and they cannot be proactive in following up on the care of these patients. This results in an increasing risk that these patients will not receive the care they need in a timely manner. There is an increasing need for more doctors specialising in the care of older persons and this is a national issue. (2) There are currently no clear guidelines as to how these patients should best be managed and there remains a serious risk that the care they receive is not holistic. (3) Patients falling in hospitals and sustaining injuries which lead to their death remains a matter of grave concern. **Bristol Ambulance Emergency Medical Services** (4) The paramedic working within the cohort area did not complete a falls risk assessment in accordance with the JRCALC guidelines following the admission of a patient who had just had a fall at home. (5) The other two ambulance staff did not seem to understand that Mr Cruse was a falls risk, they did not consider that he was at a greater risk of falls and did not consider that any further action should have been considered or taken. (6) An investigation took place but the staff did not identify any learning and did not undertake the case study to help them identify such patients in the future. Bristol Ambulance Emergency Medical Services still run some cohort areas alongside South Western Ambulance NHS Foundation Trust, and continue to convey patients to hospital. The evidence given on behalf of this organisation did not provide reassurance that this is a matter which the ambulance service have adequately addressed. There is a real concern that ambulance staff throughout the organisation may not be adequately trained in recognising and dealing with patients who have had a fall or falls.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you the Secretary of State for Health, and Bristol Ambulance Emergency Medical Services, 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 **22 January 2024**, the coroner, may extend the period.

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

	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 [redacted], friend if the Deceased, to the Royal United Hospitals NHS Trust and to the Chief Coroner. I have also sent it to South Western Ambulance Service NHS Foundation Trust who may find it useful or of interest, as I understand that they work very closely with Bristol Ambulance Emergency Medical Services. 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	27th November 2023 Signature Debbie Rookes **Assistant Coroner**