HM Senior Coroner
for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **NHS England** **PO Box 16738** **Redditch** **B97 9PT** **The Rt Hon Victoria Atkins MP** **The Secretary of State for Health & Social Care** **39 Victoria Street** **London** **SW1H 0EU**
1	**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 26th of July 2021, I opened an Inquest into the death of Margaret Avril Burman. During the course of the Inquest final hearing, I was told by the family that Margaret preferred to be known by her second name, Avril, and I will be referring to her by that second name for the remainder of this report. Avril died at Salisbury District Hospital here in Wiltshire on the 13th of July 2021. She was aged 88 years old. On the 5th of April 2024, I concluded Avril's Inquest. I found the medical cause of death was as follows: - 1a. Intracranial Bleed 1b. Head Injury 1c. Fall II. Dementia, Atrial Fibrillation (on Anticoagulation) I additionally recorded a short form conclusion of Accident and in response to the question as regards when, where and how (by what means Avril came by her death) I recorded in box 3 of the Record of Inquest as follows: "Margaret, who preferred to be known by her second name Avril, died on 13 July 2021 at Salisbury District Hospital in Wiltshire as a result of an intracranial bleed. Avril had an unwitnessed fall at around 2130 on the ward during the evening on 6 July 2021 resulting in the head injury. Avril had a history of falls pre-admission and had dementia. Avril also had atrial fibrillation and was on anticoagulation which was being given to her at the time of the fall despite doctors' directions that it be stopped, given on 30 June 2021 and 1 July 2021. The Apixaban and the dementia more likely than not contributed to the severity of the bleed. The Falls Risk Assessment did not address the known falls risk which was high and there was no enhanced care documentation, although Avril was in a ward bay where but for the non-availability of a Health Care Assistant that shift, would have been present and more likely than not would have avoided the severity of the injury by managing the fall."

4	**CIRCUMSTANCES OF THE DEATH** Avril had a history of falls and was admitted briefly to Salisbury District Hospital on the 26th of June 2021 having had what was believed to have been an unwitnessed seizure. She was discharged the following day but then re-attended and was subsequently re-admitted on the 28th of June 2021 following a fall and possible long lie. There was concern that Avril had a urinary tract infection and she was prescribed appropriate antibiotics. Avril was also in receipt of Apixaban for atrial fibrillation and although there are notes on 2 occasions where a doctor has directed that the medication be stopped, however, this did not appear to happen before she was found having fallen on the ward on the 6th of July 2021. As you will be able to see from what I have recorded in relation to the when, where and how in box 3 of the Record of Inquest, relevant risk assessment falls were not appropriately completed by nursing staff although I did accept evidence that Avril had been placed in a bay with a small number of other patients on Spire Ward with the intention that overnight there would be a Healthcare Assistant who would monitor specifically those patients in that bay and assist any patient who was found out of bed to either return to bed or for example be supported and assisted to the lavatory. Unfortunately, especially back in 2021 I heard that there were significant staffing issues with staff off sick because of COVID and challenges in relation to temporary staff unwilling to provide additional support. As a consequence, the Healthcare Assistant was unavailable, and no replacement was secured for the overnight shift and consequently there was no person able to monitor the ward bay where Avril's bed was located. Her fall was unwitnessed by staff and as a consequence of her fall, she sustained a traumatic head injury from which she died on the 13th of July 2021.
5	**CORONER'S CONCERNS** As I have previously indicated in a Regulation 28 Report submitted to you (Raymond Eggleton dated 17th November 2023 which remains unanswered by you) (Department of Health)) falls in the hospital environment do happen, however, I was of the view in Avril's case that had there been an appropriate Healthcare Assistant present then Avril's fall and death more likely than not would have been avoided. During the course of the Inquest, I heard evidence from the Hospital's Falls Specialist, [redacted] who indicated that whilst staffing issues have improved there remains a difficulty ensuring appropriate staffing especially when responding to the ever-changing needs on wards where they are occupied by people at risk of falls . She explained to me that in relation to 2 wards in particular, one of which included Spire Ward which is a general geriatric surgical ward and the other which is a trauma and orthopaedic ward, both of which can take approximately 30 patients, that having conducted her own analysis it transpired that of those admitted onto both those wards that approximately 80% either had a history of falls or the reason for their admission related to a fall. Of those at risk of a fall where the enhanced care toolkit had been deployed, she told me that 70% of those at falls risk required and warranted 1 to 1 support. Generally, these wards have a nursing ratio of between 1 to 8 patients or sometimes 1 to 6 patients with appropriate Healthcare Assistant support. As you can see in relation to a ward of 30 patients, a situation starts to present itself where the majority of personnel on the ward are not providing nursing support but are providing 1 to 1 falls mitigation support, and there simply are not the resources available to provide such cover. As a consequence, where there is an identifiable falls risk, the situation arises and continues at the moment where those patients are not being appropriately safeguarded against the risk of falls on wards. Especially where patients have conditions such as Dementia and Alzheimer's it can sometimes be the case that it only takes a relatively minor collapse to cause a significant head trauma that leads to death. The position is further compounded by the fact that I was told the hospital is confronted with the additional problem that it can have up to 70% of those patients on these 2 wards being in a condition where they are medically stabilised and fit to be discharged but due to lack of appropriate care in the community they are remaining on the wards. The longer they remain on the wards the greater the risk of falls especially if they are medically stabilised when in such

	circumstances, they are more likely to be mobile. I asked [redacted] as to how she thought that improvements could be made and she indicated to me in her evidence that she was of the view that there should be national leadership and a standardised toolkit when assessing falls risks on hospital wards and that there should also be a greater degree sharing of learning where methods of good practice have been adopted by other Trusts that could easily be adopted by Trusts where this is a challenge. As I indicated in Mr Eggleton's Regulation 28 Report, the problem here is multifactorial but as it remains at the moment, I am concerned that the elderly on hospital wards are at significant risk of sustaining a traumatic and fatal injury by having a fall on a ward due to the unavailability of appropriate and necessary falls mitigation measures. The resolution of this problem is not about the amount of money or the increase in money that is injected into the National Health Service and my concern is that a more strategic approach is required. More money may well indeed be injected into the National Health Service but with inflation as it has been and with wage rises that have taken place in real terms the increase maybe small and the reality is that in real terms it may amount to a reduction in what can be purchased with that money. The commitment to provide 5000 extra "core" beds to deal with increasing demand is only going to add to the concern unless this issue is addressed. As I have stated in my last Regulation 28 Report dealing with this issue, the problem is multifactorial, but it is a solution in respect of which the government undoubtably has a crucial and essential role to play.

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 10th June 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 Persons, [redacted], Salisbury District Hospital Family of Avril 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 April 2024 Signature [signature] David Ridley, Senior Coroner for Wiltshire & Swindon