NHS
Somerset
NHS Foundation Trust

Yeovil District Hospital
Higher Kingston
Yeovil
BA21 4AT

Date : 30 October 2025

Mrs Vanessa McKinley
Area Coroner for the County Somerset

[redacted]

[redacted]

Dear Mrs McKinley

REGULATION 28 REPORT – PREVENTION OF FUTURE DEATHS – Edwin PRICE

I am writing in response to your correspondence dated 28 August 2025 regarding Regulation 28 of the Coroner's (Investigations) Regulations 2013, following the inquest into the death of Mr Edwin Price, which concluded on 27 August 2025.

May I take this opportunity to express my personal condolences to the family for their loss.

I have set out below the matters of concern raised in your report and our response as a Trust.

Your concerns were focused on the lack of a falls risk assessment for Mr Price, no communication with his nursing home following his admission that led to our failure to implement adequate mitigations to reduce the risk of him falling, and an apparent lack of action taken within the Trust to address these gaps.

In April 2023 Somerset NHS Foundation Trust (SFT) and Yeovil District Hospital (YDH) merged organisations to become one Somerset NHS Foundation Trust, and there has been a period, ongoing, where there has been alignment of policies and guidance across the new Somerset NHS FT organisation. At the time of Mr Price's fall, colleagues in YDH were still working to the legacy policy in place which did not have a time frame in which a Falls Risk assessment was to be completed. The legacy Somerset FT policy and the newly merged one organisation Somerset FT policy both state that an individual must have a Falls Risk Assessment within 12 hours of admission to an inpatient ward, and that this is reviewed if the person moves to another inpatient ward / has a fall / their condition changes.

Completion of the falls risk assessment is now mandatory within 12 hours of admission, with weekly reviews, or sooner if the patient's condition changes. Patient risk status is clearly displayed on 'Patient at a Glance' boards, behind the patient's bedspace.

The Deputy Associate Director of Patient Care (ADPC), Matron and Ward Managers are monitoring compliance with the completion of the falls risk assessments and although these are audited monthly through our Core Nursing Metrics, additional spot audits are also being undertaken. These have shown an increase in compliance, however further strengthening in this area is required to ensure an embedded and sustained process of compliance with the expected 12-hour target

[redacted]

We recognise that good communication with patients and people who matter to them is key to ensuring good quality care. We acknowledge that involvement with Mr Price's nursing home would have provided us with additional information to assist us with assessing his risks and this will be used as part of the information shared with colleagues in development of this programme of work. Had the Care Home been contacted to gather the important and vital information required to support Mr Price's transfer of care, the appropriate and proportionate safeguards would have been put in place.

The Trust has established a personalised care improvement group that is focusing on the 'no decision about me without me' programme. This work is being led by Clare Boobyer-Jones, Director of Allied Health Professions, and will be based on good communication with patients and those that matter to them. The basis for this is understanding what matters to patients, families and carers and ensuring that they are able to participate in decision making. We are actively identifying projects across our wards to help deliver care in this way.

In response to this incident, our acute medical unit (AMU) has introduced a checklist to be completed on admission which involves contacting the patient's family, care home or community hospital to gather more detailed information about the patient (see appendix 1). The guidance on the patient's baseline function and the usual mitigations that are in place in their usual residence to reduce the risk of harm

We acknowledge also that an appropriate risk assessment on admission would have assisted us to identify Mr Price's risk more clearly and put sufficient mitigations in place to reduce the risk of harm to him. In addition to the risk assessment, to help us reduce risk to patients, we use an Intentional Rounding tool to assist with care planning and patient involvement. At a minimum a patient is seen two hourly and engaged with, this is in addition to physical observations. From our recent reviews, including learning from Mr price's case, it has become clear that there has been a lack of clarity around the purpose and process associated with the meaningful delivery of Intentional Rounding across the Trust.

In response to this, a Quality Improvement (QI) project was commenced with an aim to address these variances and improve the overall understanding, application and staff culture, leading to increased patient safety, a reduction in harm and ultimately better outcomes for patients. Since testing the specific role modelling approach for Intentional Rounding across 11 pilot wards, there has been improved awareness and understanding from colleagues, a reduced number of reported incidences and / or concerns, with fewer patients suffering harm through falls. A new tool was developed which will capture more accurately the care delivery 'in real time' and be patient centred to reflect the needs of the individual patient. The acute medical unit has started rolling this new form out

At the time of Mr Price's admission, the new Intentional Rounding tool had not yet been implemented on the ward. Although an Intentional Rounding document was available, it did not meet the expected standards. The newly appointed ward manager has since prioritised the improvement of Intentional Rounding, alongside enhancing the quality of falls risk assessments.

Within our medical service group, the ADPC for medicine, Deputy ADPC and Matrons are carrying out patient and relative engagement walk rounds across all our wards, during visiting hours, this has been very positive and allows us to hear about areas of notable good practice and areas of concerns that need to be addressed.

The medical matrons are now working 20% of their time clinically on our wards each week, supporting with training and education and supporting with the identification of our high-risk patients and are leading ward rounds and safety huddles with the ward senior leadership team.

We have launched a test of change with a 5 day a week supernumerary role, titled the Quality and Safety Lead Nurse (2 full time posts) within the medical services group, with clear aims, objectives and job planning, this will follow QI methodology and falls will be part of their patient safety remit. The ADPC and Deputy support a daily review of all incidents reported and the matrons will also review and ensure that all measures and steps have been taken to mitigate any further risk of harm for the patients in our care.

I hope that this response has addressed the concerns aet out in your Regulation 28. Please do not hesitate to contact me if you require further information.

Yours sincerely

[redacted]

Chief Executive
Somerset NHS Foundation Trust

Appendix 1

NHS
Somerset
NHS Foundation Trust

Residential/Nursing home handover (To call patients home on admission to ward)

- **Are they at risk of falls? How many falls in last 12 months? Preventative measures used at home?**

- **Baseline mobility? Aids?**

- **Communication: Any issues? Glasses? Hearing aids? Communication aids?**

- **Pressure areas: Intact? Damage? Dressing used? DN involvement?**

- **Diet: Are SLT involved? Any preferences?**

- **Toileting: Continent? Incontinent? Catheter? When was it changed?**

- **NOK: Is there LPOA? Are they involved?**