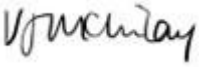
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Somerset NHS Foundation Trust**
1	**CORONER** I am Vanessa McKinlay, Area Coroner for Somerset
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 18 November 2024 I commenced an investigation into the death of Edwin Everett Milne Price. The investigation concluded at the end of the inquest on 27 August 2025. The conclusion of the inquest was that Mr Price died having sustained injuries in a fall in hospital, to which gaps in his falls risk assessment and management made a contribution.
4	**CIRCUMSTANCES OF THE DEATH** Mr Price lived at The Knoll Nursing Home in Yeovil where he was dependent on hoisting for all transfers. He had a history of falling onto the floor from his bed. There had been approximately twenty such incidents. The nursing home implemented mitigation measures of a low rise bed and a crash mat on the floor to minimise the risk of injury. Mr Price was admitted to Yeovil District Hospital on 29 September 2024 with diabetic ketoacidosis. The oral evidence given by the Ward Manager at the inquest was that his falls risk assessment was not completed within the expected time of 24 hours from admission and that the expected communication about his falls risk with the nursing home did not take place. The hospital staff were therefore unaware of Mr Price's specific risk of falling out of bed. No mitigation measures were implemented, namely moving Mr Price to a bay where he could be more easily observed, providing a low rise bed and providing a crash mat. On 30 September 2024, Mr Price fell out of bed onto the floor. He sustained a fractured humerus and a retroperitoneal bleed, the latter being the cause of his death on 1 November 2024. The medical cause of death provided by [redacted] (Medical Examiner) was: 1a Retroperitoneal Haematoma (anticoagulated) II Type 1 Diabetes Mellitus; Pulmonary embolus

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. – 1. The falls risk assessment was not completed within the first 24 hours of admission to the ward. 2. Had it been completed, the risk assessment would have involved obtaining information from the nursing home as Mr Price was unable to communicate. 3. A risk assessment would have identified Mr Price's specific risk of falling out of bed. 4. The lack of a risk assessment meant that mitigation measures were not in place. 5. The lack of mitigation measures made a more than minimal contribution to the extent of Mr Price's injuries and therefore to his death. 6. No subsequent action has been taken by the ward to address the gaps in the falls risk assessment and management process when patients are admitted from care homes.

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 23 October 2025. 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] (Mr Price's stepdaughter) I have also sent it to the Medical Examiner, NHS England and the CQC. 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. She may send a copy of this report to any person who she 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	**28 August 2025** Signature:  **Vanessa McKinlay** **Area Coroner for Somerset**