Frimley Health
NHS Foundation Trust

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23 May 2026

PRIVATE AND CONFIDENTIAL

Mr R Simpson Assistant coroner
Coroners' office
Reading Town hall
Blagrave Street
Reading RG1 1QH

Dear Sir

Trust Response to Regulation 28 Report for the Prevention of Future Deaths.

RE: Inquest touching the death of Mr John Tarrant.

The coroner's concerns are replicated in bold below**:**

1. Falls risk assessments.
Only 2 falls risk assessments were carried out after Mr Tarrant arrived at the hospital. Both falls risk assessments used the Hester Davis scoring system, but both had carried out based on incorrect data. The falls risk assessments both resulted in a low-risk outcome which was not correct. Mr Tarrant should have been graded as a moderate risk even prior to his fall. Some of the data entered into the risk assessment tool was objectively wrong. For example, in the risk assessment carried out hours after his fall it stated that he had not fallen before.

I heard that the Trust did not have a way of assessing and auditing the accuracy of these risk assessments. Whilst I found that the errors in this inquest did not contribute to Mr Tarrant's death incorrect risk assessments can lead to inadequate falls mitigation measures being put in place and incorrect information being provided to staff.

A falls risk assessment was performed on attendance in the Emergency Department and following Mr Tarrant's inpatient fall. For Mr Tarrant's admission, these 2 falls risk assessments were all that was required. (Patients should be risk assessed for falls on admission to clinical areas, after a fall, or when their clinical picture changes). However, the Hester Davis scoring system which was in use at the time was calculated inaccurately by staff. Prior to Mr Tarrant's inquest, the Trust had already acknowledged that the Hester Davis falls risk assessment was not intuitive for staff to use and, scoring mistakes were noted. Therefore, the Trust re-designed a new falls risk assessment which was launched on the electronic patient record system. The new falls risk assessment was in progress at the time of Mr Tarrant's fall, and the Trust had been working on this for >12 months.

The revised falls risk assessment is based on national guidance and is much easier for staff to use. The new risk assessment now grades patients as either "at risk", or "not at risk" of falls rather than using the previous grading score of 'low' 'moderate' or 'high' risk. This new assessment significantly reduces the likelihood of incorrectly scoring a patient at risk. The revised risk assessment has been in use for the entire Trust since September 2025. We apologise if this initiative was not communicated to the coroner prior to or during the inquest hearing on 30 March 2026.

For further context, whilst in Mr Tarrant's case the risk score was incorrectly deemed to be 'low' rather than 'moderate' in accordance with the scoring system at the time, even if the correct risk score of "moderate" had been correctly identified, the falls mitigating measures in place would not have changed. For example. and a green wristband used as a quick visual prompt for being at risk of falls. At the time of the fall, Mr Tarrant was in the bathroom seated on the toilet. The HCA attended to check on Mr Tarrant. He reported he did not require any assistance. He had non-slip footwear in place; the floor was dry and there were no environmental hazards. The HCA advised she would wait outside the door in case he required assistance and to allow him privacy. Shortly after she heard a noise and found him on the floor. Unfortunately, Mr Tarrant tried to get up from the toilet alone and fell.

The Trust has a Harm Free Care Audit Programme which aims to promote high standards of nursing care. The Harm Free Care Audit Programme was introduced in July 2025 as a monthly audit, to be completed by senior ward leaders, and encompasses key aspects of nursing care including falls prevention. Twenty-five per cent of the patients in a clinical area are audited. This audit tool is one of several methods available to monitor compliance with nursing care standards, including spot checks on the ward and compliance monitoring by senior ward leaders.

The target of compliance for this audit is 90%. Whilst the time limited initial assessment scores (to risk assess a patient within 6 hours of being admitted to a ward) do not reflect reaching the target, the reassessment compliance indicates that falls and bedrail assessments are being completed but may be documented more than 6 hours post arrival on the ward. The reassessment figures are consistently above target.

The Trust has a dedicated quality improvement workstream to reducing the number of inpatient falls and this is led by one of our senior nurses. This workstream has been in place for the last 2 years. Nationally, the Royal College of Physicians state that approximately 20% of inpatient falls are preventable. Over the last financial year, the Trust has reduced the incidence of inpatient falls by 12% and the incidence of inpatient falls is currently at the lowest number the Trust has had for the last 5 years. It was unfortunate this was not communicated to the coroner as this would have provided a clearer view of initiatives undertaken in the Trust.

As part of the quality improvement workstream, the Trust has a multidisciplinary Falls Steering Group to oversee delivery, ensuring the implementation of evidence-based prevention strategies and sustained organisational focus. In the last financial year falls prevention information has been updated to better support patients and families in understanding risks and contributing to prevention, via a leaflet. These are available in clinical areas.

Prior to the inquest, two safety campaigns had already been initiated, including the relaunch of 'Stay in the Bay' and 'Call Don't Fall'. Both have now been reinforced across all sites. 'Call Don't Fall' posters have been displayed in clinical areas, including all patient bathrooms in the organisation. 'Stay in the Bay' lanyards have been provided to all clinical areas for staff to use, to empower staff to decline leaving the bay / specific patient if providing enhanced / 1:1 care.

Targeted falls prevention training has been delivered across Heatherwood Hospital, Heathlands and Farnham Rehabilitation settings, alongside the introduction of a 'Falls Champion' programme to embed best practice at ward level. Training has been delivered to the fall's champions, and this will occur as a minimum of every 3 months.

The Trust has trialled new hospital beds with integrated falls alarms and the Trust has invested in some of these beds. Falls data analysis has been used to identify high-risk clinical areas that would benefit most from these beds and other interventions.

Orthostatic blood pressure guidance has been standardised and embedded within ward observation processes to improve identification and management of falls risk factors. Easy to follow laminated guides on the correct assessment of lying and standing blood pressures have been attached to all observation machines in clinical areas.

A simplified multidisciplinary team review form has been developed to support frontline teams in undertaking timely, structured post-falls reviews and identifying learning. This is also available on our incident reporting system, 'In-Phase'. The Trust monitors the number of inpatient falls and in which clinical areas these occur and the data is shared with the senior leaders of the clinical areas every month.

The Trust is also in the process of implementing a national campaign for falls prevention, the 'Think Yellow' campaign. This is planned to strengthen staff and

patient/visitor awareness and promote consistent falls prevention behaviours across all sites. Currently this has been piloted in both Emergency Departments. The initiative uses a 'think yellow' pack which consists of a yellow patient blanket, wristband and non-slip socks to quickly help staff identify the patients who are at risk of falls. The plan is that this will be rolled out to the rest of the organisation by the end of July 2026.

The Trust has also identified advanced falls monitoring solutions are available. A trial of new falls prevention equipment (sensors for beds, chairs and toilets) is currently planned for a Care of the Elderly ward at Frimley Park Hospital, with a planned trial to also include Farnham Community Hospital – rehabilitation ward with single en-suite rooms. If the trial is successful, a phased rollout of the equipment will occur across the Trust.

2. Anti coagulation risk awareness.
The doctor who reviewed the CT results and neurosurgery advice after Mr Tarrant fell did not appreciate the urgency of the situation. I found in this inquest that due to timing issues this was not likely to have affected the outcome for Mr Tarrant.

I heard from the consultant witness that the risks of anticoagulation are poorly understood. The post falls proforma was reviewed in court and, whilst it asked whether the patient was on anticoagulation medication, it did not provide a prompt about this during the post fall medical planning section. This led to a concern that the importance of considering administering an anticoagulation reversal medication and the urgency of such a need may be underappreciated.

Mr Tarrant was correctly anticoagulated with warfarin (INR target 3-4) for a prosthetic aortic valve.

On admission, his Warfarin was correctly held when he presented unwell as his INR over 6 and therefore outside the therapeutic range. INR frequently becomes unstable when patients are unwell. A single dose of clarithromycin (antibiotic) was administered, which can interact with warfarin and may have contributed to the subsequent high INRs. However, this potential interaction was recognised during the post-take ward round, and the antibiotic was changed to doxycycline. Despite the high INR level, there was no evidence of active bleeding and standard practice would be to allow the INR to reduce naturally given the critical indication for anticoagulation in Mr Tarrant's case.

When Mr Tarrant fell and the CT scan showed a small subdural bleed, as is standard practise, our tertiary neuro-surgical centre was contacted. In addition to advice on neurosurgical management their advice with regard to the anticoagulation was to contact Frimley haematology for consideration regarding reversal of anticoagulation. Unfortunately, haematology was not contacted. Vitamin K was administered to Mr Tarrant , however had the on-call haematology consultant been called, they would have advised correction with Beriplex (PCC concentrate) <u>and</u> Vitamin K.as Beriplex has a faster action than Vitamin K. Whilst the risk of stroke or valve obstruction would have

been temporarily increased by reversal, extension of the subdural bleed was at the time the greater risk.

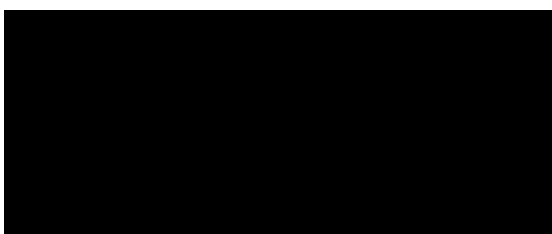
Our consultant haematologist on-call service is available 24/7, 365 days of the year, and it is very common for the consultant haematologist on-call to be contacted for advice in just this scenario. The Trust does not accept that the risks of anticoagulation are 'poorly understood', which was evidence provided to the coroner during the hearing. One of the Trust's Consultant Haematologists confirms that in her experience clinicians are very aware of the risks of anticoagulation together with the risks of inappropriately stopping these agents. In other words, it was probable that the evidence regarding a 'poor understanding' was related to the risk benefit balance which is what can make such decisions difficult. There is good understanding of the risks in the case of a bleeding anticoagulated patient and clear understanding of where to obtain expert advice.

The availability of expert Consultant Haematologist advice 24/7, 365 days of the year is also strongly reiterated at the resident doctor's induction training to the Trust, and the clear evidence is this is regularly accessed.

In addition, the Trust has long-standing published guidance on reversal of all anticoagulant agents, and these are available on the Trust intranet, and this is easily accessible on individual's mobile devices. The guideline has been in place since 2021. At the time of Mr Tarrant's incident, the Trust guidance was in place and available for all to access. The chief medical officer has monthly safety briefings in person to all resident doctors. Going forward, this briefing will be aiming to increase awareness to all the importance in escalating to senior level in such circumstances where there is a risk of continuing anticoagulation and/or where reversal is a consideration.

Trust guideline - Emergency Reversal of Oral Anticoagulants v2

Yours sincerely



Chief Executive Officer