Humber Health Partnership

Legal Service Department
Hull Royal Infirmary
Anlaby Road,
Hull,
HU3 2JZ

29 May 2026

PRIVATE AND CONFIDENTIAL
Professor Marks,
The East Riding and Hull Coroner's Office
The Guildhall
Alfred Gelder Street
Hull
HU1 2AA

Dear Professor Marks,

Re: Regulation 28 Report to Prevent Future Deaths – Raymond John Moran

Thank you for your Report to Prevent Future Deaths dated 25 February 2026, made under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, following the inquest touching upon the death of Mr Raymond John Moran.

On behalf of Humber Health Partnership, I would like to express our sincere condolences to Mr Moran's family. The Trust has carefully considered the matters of concern identified in your report and has reviewed the circumstances of this case at both local and group level.

We note your concerns that the falls risk assessment was inaccurate, was not updated as it should have been, and that the documentation was incomplete. We also note your observation that action may include ensuring assessments capture relevant information about recent falls in the community, emphasis on completing forms accurately and contemporaneously, and ensuring that training and auditing of inpatient falls continues and can be demonstrated and evidenced.

The Trust accepts that the multifactorial falls assessment and associated documentation on transfer to Ward 32 were not completed as required by policy and that documentation standards should have been better in this case. The Trust also accepts the need to reinforce reassessment on transfer between clinical areas and the need for complete and contemporaneous documentation.

However, the Trust considers it important to clarify that the patient's falls risk had been recognised during the admission and that a number of falls prevention measures were in place prior to the fall. The post-fall debrief and SWARM review record that the patient had access to the call bell and had previously used it, had non-slip socks in place, had an appropriate bed rail assessment with bed rails raised in accordance with that assessment, had a Zimmer frame at the bedside, and had a mobility plan of Zimmer frame with assistance of two. The reviews also record that he was identified as being at risk of falls, that a falls risk assessment had been completed on admission, and that the relevant falls prevention measures were in place, albeit with shortcomings in reassessment and documentation on transfer.

Following the incident, the Trust undertook both an immediate post-fall debrief and a multidisciplinary post-fall SWARM review. Those reviews identified local learning, including the need to strengthen documentation and reassessment processes, particularly in relation to ensuring multifactorial falls assessments are completed and updated on transfer, ensuring recent falls history and other relevant risk factors are clearly reflected in the assessment, ensuring formal assessment of suspected confusion or delirium is undertaken where indicated, ensuring lying and standing blood pressure is reconsidered when a patient becomes mobile enough for this to be completed, reinforcing expectations regarding timely medical review after a fall, and improving the consistency of contemporaneous recording of falls prevention activity and post-fall management.

Action taken and proposed

1. Immediate local review and learning
The incident was subject to an immediate post-fall debrief and subsequent multidisciplinary SWARM review. These identified a number of specific actions for Ward 32, including:

- ensuring all staff are in date with mandatory falls prevention training.
- ensuring patient education regarding use of the call bell is documented.
- reinforcing the expectation of timely medical review following a fall.
- ensuring 4AT assessment is undertaken where confusion or delirium is suspected.
- ensuring lying and standing blood pressure is undertaken when patients become sufficiently mobile.
- ensuring a multifactorial falls assessment is completed on transfer to a clinical area; and
- providing MDT education to support completion of hourly AFLOAT checks.

2. Reinforcement of transfer reassessment requirements
The Trust has reinforced with ward teams the requirement that, when a patient transfers between clinical areas, the relevant assessments must be reviewed and repeated in accordance with policy. This learning has been recognised not simply as a ward-specific issue but as a theme relevant to inpatient ward areas more broadly. The SWARM expressly identified this learning as applicable group wide.

3. Training and ward-level compliance
Ward 32 training compliance has been reviewed. The target for falls-related training is 85%. The current Ward 32 figures supplied for the purpose of this response are:

- Fallsafe Registered Nurses: 81%
- Falls Prevention non-registered staff: 77.8%

Targeted action is being taken locally to improve compliance to or above target, including review of outstanding staff, completion of required learning, and oversight through ward and divisional governance arrangements.

4. Additional ward-level assurance measures
Further local assurance measures are being put in place within Ward 32 to improve completion of documentation and reassessments. These include increased spot checks by ward leadership, review of whether assessments have been completed at the start of the day and strengthened local oversight involving ward sisters and junior sisters. The purpose of this is to embed compliance and ensure incomplete documentation is identified promptly and addressed.

5. Targeted support from the Falls Prevention Team
The Falls Prevention Team has agreed to provide additional practical support to Ward 32, including educator input to work directly with staff on the ward in relation to the correct completion of assessments and associated documentation. This support is intended to help embed practice and improve consistency.

6. Specialist audit / accreditation review
Ward 32 is being prioritised for a specialist falls audit / accreditation review to identify any remaining gaps, to provide targeted recommendations, and to support the ward in achieving the required standard. This will also provide further assurance regarding whether the actions taken have resulted in measurable improvement.

7. Group-wide governance and strategic action
The Trust's response is not limited to Ward 32. The learning from this incident has been considered through the wider group falls prevention work programme and strategic action planning.

The Trust has a group falls prevention strategic action plan, including closed actions and current actions, which is being used to support wider organisational learning, oversight and improvement.

8. Clarification regarding falls terminology
By way of clarification, the Trust's falls prevention process is based on a multifactorial assessment of risk and identification of those patients who may be at greater risk of falling, rather than reliance solely on fixed stratification terminology. The Trust nevertheless accepts that, in this case, the documentation and reassessment process fell short of the required standard and that the key issue is to ensure robust assessment, review and recording of relevant risk factors.

9. Monitoring and assurance
The Trust will monitor the effectiveness of these actions through local and group governance processes. This will include review of:

- training compliance.
- completion and quality of multifactorial falls assessments.
- reassessment on transfer between clinical areas.
- documentation of patient education and falls prevention measures.
- evidence of delirium / confusion assessment where indicated.
- compliance with post-fall review expectations; and
- findings from ward-level and specialist audit activity.

The Trust is committed to learning from this inquest and from your report. We are grateful that the matters of concern have been identified and will continue to use this learning to strengthen falls prevention practice, documentation standards and assurance processes across the organisation.

Yours sincerely,

Group Chief Executive