



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	<p>REGULATION 28 REPORT TO PREVENT DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1 Frimley Health NHS Foundation Trust</p>
1	<p>CORONER</p> <p>I am Robert SIMPSON, Assistant Coroner for the coroner area of Berkshire</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 02 May 2025 I commenced an investigation into the death of John Albert TARRANT aged 84. The investigation concluded at the end of the inquest on 30 March 2026. The conclusion of the inquest was that:</p> <p>On the 30th April 2025 John Albert Tarrant died at the Wexham Park Hospital, Slough. He had an unwitnessed fall whilst an inpatient on the 29th April 2025 during which he sustained a bleed to the brain. This bleed worsened later that evening and became unsurvivable.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Mr Tarrant attended Wexham Park Hospital by ambulance on the 26/04/2025. On admission he was suffering from a chest infection, delirium and his INR was 6.8. He was unable to weight bear.</p> <p>He had a medical history including atrial fibrillation, ischaemic heart disease and a prosthetic aortic valve. He was on long term anticoagulation and was prescribed warfarin.</p> <p>He was treated with antibiotics and his warfarin was held to allow his INR to reduce to his target of 3-4.</p> <p>Over the course of the 26/04/2025 to the 29/04/2025 his delerium reduced and he became alert and oriented. He also started to mobilise and walked well on the 29/04/2025.</p> <p>His INR remained elavated throughout his stay in hospital.</p> <p>On the 29/04/2025 at about 4.30pm he was noted to be out of bed. An HCA located him in the bathroom and checked upon him. He was stood washing his hands at the sink and stated that he was OK. The HCA waited outside the door to escort him back to bed, there was a noise and when she looked again Mr Tarrant was on the floor.</p> <p>A CT scan revealed a very small bleed. Neurosurgery were consulted and advised against surgery. They recommended seeking advice from cardiology and heamatology with a view to reversing the effects of the anti-coagulation. A reversal agent was not administered prior to Mr Tarrant suffering a further decrease in consciousness and becoming unresponsive.</p>



	<p>A further CT scan revealed an unsurvivable bleed in the brain. Mr Tarrant died approximately 9 hours after his fall.</p>
5	<p>CORONER'S CONCERNS</p> <p>During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows: (brief summary of matters of concern)</p> <p>1. <u>Falls risk assessments.</u> 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.</p> <p>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.</p> <p>I heard that the Trust did not have a way of assessing and auditing the accuracy of these risk assessments.</p> <p>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.</p> <p>2. <u>Anti coagulation risk awareness</u> 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.</p> <p>I heard from the consultant witness that the risks of anticoagulation are poorly understood.</p> <p>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.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by May 25, 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:</p> <p>Mr Tarrant's family.</p>



I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.

I may also send a copy of your response to any person who I believe may find it useful or of interest.

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 Dated: 30/03/2026



**Robert SIMPSON
Assistant Coroner for
Berkshire**