Ms Sally Robinson
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National Medical Director
NHS England
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[redacted]

7 August 2026

[redacted]

Dear Ms Robinson,

Re: Regulation 28 Report to Prevent Future Deaths – Pauline Margerat Bradley who died on 8 November 2025.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 24 June 2026 concerning the death of Pauline Margerat Bradley on 8 November 2025. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Mrs Bradley's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Mrs Bradley's care have been listened to and reflected upon.

Your Report raised concerns around the following:

1. Lack of communication on the ward with families of patients who are able to provide support.
2. Lack of falls mats or sensors in the cubicles on Ward H90 Hull Royal Infirmary.
3. Cubicles being left unmonitored for a period of time due to staff being engaged in handover, despite optimal staffing levels.

NHS England recognises that regarding the concerns raised in your Report, it would be advisable for trusts to review how their practice aligns with existing national clinical guidance and quality improvement resources for falls assessment and prevention. NHS England commissions the National Audit of Inpatient Falls which provides substantial resources to support improvement work. Trusts should ensure that their practice is in alignment with National Institute for Health and Care Excellence (NICE) guidance, including the replacement of any falls risk assessment or screening tools that stratify risk and lead to 'blanket' interventions. Instead, the focus should be on individualised assessment and tailored intervention plans, as this approach may have better identified the family's willingness to be involved, as well as the increasing risks associated with the patient's respiratory infection and the use of a single cubicle, which likely reduced opportunities for line-of-sight observation.

NICE guidance around fall assessment and prevention in older people and in people 50 and over who are at high risk also highlights the limited evidence base for the effectiveness of environmental interventions, such as movement sensors, whilst

acknowledging that further research in this area is needed. A more individualised assessment of Mrs Bradley and of other patients at risk of falls may have supported more effective use of limited resources.

Concern 1 – Lack of communication on the ward with families of patients who are able to provide support

NHS England is disappointed to hear that the family were not informed that they could provide support to their family member as hospital providers should be encouraging family, carers and friends to visit and provide open and flexible arrangements based on the patient's preferences and needs. This should be directly addressed by the Trust.

Concern 2 – Lack of falls mats or sensors in the cubicles on the Ward H90 Hull Royal Infirmary

NHS England advise that provider organisations should have a trust policy or guideline that sets out the use of bed and chair sensor alarm mats when used as part of a patient's individualised falls prevention plan. Sensor alarm mats are an early warning system to highlight to staff when a patient who is at risk of falling has gotten up from the bed or the chair; the pressure on the mat is removed and the alarm on the falls monitor will sound. Sensor alarm mats on their own, will not prevent a patient from falling and only work best when the patient has been carefully assessed that they would benefit from the use of a sensor alarm mat, and they form part of an active falls prevention plan.

The decision to use a sensor alarm system must be made following a holistic multidisciplinary risk assessment and documented in the patient's care plan and communicated to all staff, the patient and their family/carer. The use of falls mats is an operational decision taken locally as part of patient-specific falls prevention strategies.

Concern 3 – Cubicles being left unmonitored for a period of time due to staff being engaged in handover, despite optimal staffing levels

It is important to acknowledge that this incident occurred within a busy ward environment where nurses and doctors must manage multiple acutely unwell patients. Older people and people with dementia and cognitive impairment are at increased risk of falls, particularly in unfamiliar environments and when they are unwell. Falls risk assessments should therefore be performed on admission to hospital or transfer to a new environment, and regularly thereafter with appropriate interventions implemented to prevent and mitigate risk of falls as far as possible. It is important to note that not all falls can be prevented, and in this case the patient's risk of falls was assessed, reassessed post fall and increased levels of observations put in place.

NICE Guideline NG249 (2025) outlines best practice including identification of people at high risk of falls, comprehensive falls assessment covering gait, balance, cognition, continence, medications, vision and environmental factors, tailored interventions to reduce risk and continued engagement in falls-prevention strategies.

We note that your Report has also been addressed to Hull University Teaching Hospital and NHS Humber and North Yorkshire ICB who would be best placed to respond to the specific concerns raised about staffing levels on the ward.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Mrs Bradley, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

National Medical Director
NHS England