Health Board fined for failing to manage patients risk of falling

Betsi Cadwaladr University Health Board has been fined £250,000 following failures relating to patient falls in its hospitals.

Three elderly patients sustained falls in 2022 and 2023 and they all sadly died. The cause of death of two of them was identified as being as a direct result of falling.

Richard Hughes, 84 and Gwilym Williams, 74, fell at Ysybty Gwynedd in Bangor in January and June 2022 respectively, while Nancy Read, who was 93, fell at Wrexham Maelor Hospital in January 2023.

Betsi Cadwaladr University Health Board (BCUHB) was initially investigated by the Health and Safety Executive (HSE) following two other patient falls in 2020, one of which resulted in fatal injuries.

As a result, HSE took enforcement action against BCUHB that required it to implement an effective patient fall management system, including:

- ensuring patients had appropriate falls risk assessments (with clear risk controls detailed);
- that the risk assessments were reviewed and updated accordingly in the event of a patient's health deteriorating;
- that staff received training on patient falls.

The enforcement action also required BCUHB to review the patient falls policy and to ensure the entire system worked effectively. A follow-on inspection made in November 2021 identified that BCUHB were still not managing patient falls and this resulted in a further action being taken.

However, over the next two years, the three patients died and BCUHB had not implemented a system to identify and manage patient falls quickly, or provide staff with updated training.

Betsi Cadwaladr University Health Board pleaded guilty to breaching Section 3 (1) of the Health and Safety at work Act 1974 and have been fined £250,000 and ordered to pay costs of £11,766.

Speaking after the case HSE inspector Sarah Baldwin-Jones said "This is the second time this health board has been prosecuted in less than 18 months.

"These incidents could so easily have been avoided had the BCUHB followed their own adult falls policy. Effective management of patient falls includes thorough risk assessment, effective communication on risk management, monitoring and re-evaluation should the patient condition deteriorate.

"Staff and agency workers need to follow the same training pathway, ensuring those responsible for falls management have the skills to make appropriate

decisions.

“Unfortunately, these actions were not always followed and as a result some patients suffered falls, which resulted in two preventable deaths.”

The HSE prosecution was brought by HSE enforcement lawyer Gemma Zakrzewski and paralegal officer Sarah Thomas.

Further information:

1. The Health and Safety Executive (HSE) is Britain’s national regulator for workplace health and safety. We are dedicated to protecting people and places, and helping everyone lead safer and healthier lives.
2. More information about the legislation referred to in this case is available.
3. Further details on the latest HSE news releases is available.
4. HSE does not pass sentences, set guidelines or collect any fines imposed. Relevant sentencing guidelines must be followed unless the court is satisfied that it would be contrary to the interests of justice to do so. The sentencing guidelines for health and safety offences can be found here.