

Understanding Falls Risk, Prevention and Negligence in Healthcare



This guide was produced by INNEG and is based on key clinical insights shared during our January 2026 webinar When a Fall Becomes a Claim featuring Glenn Smith, Advanced Nurse Practitioner.

It is intended to support solicitors in understanding common medico-legal decision points and does not constitute clinical guidance or expert opinion on any individual case.

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Introduction

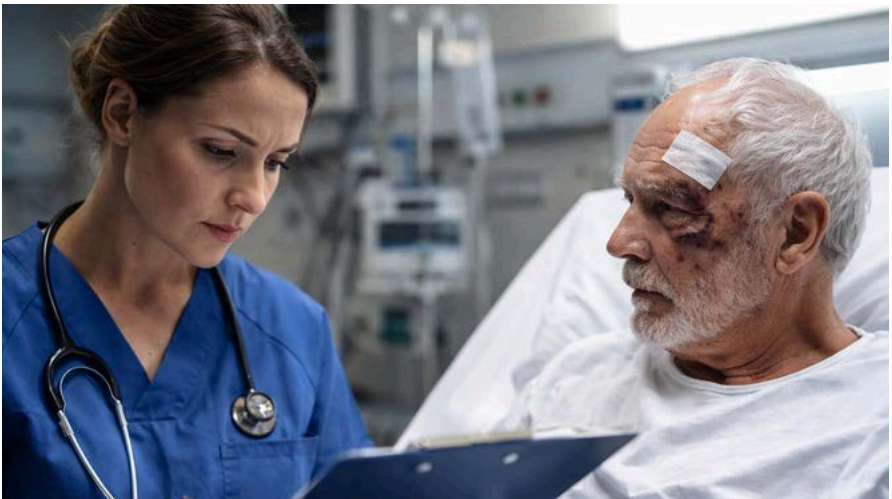
When does a fall indicate an unavoidable incident - and when does it point to a failure in care?

Falls sit at the centre of many high-value injury claims, yet liability rarely turns on the fall itself. It turns on how risk was identified, managed, reviewed, and documented, and whether the clinical reasoning behind those decisions can withstand scrutiny.

This guide provides practical insight into how falls are assessed in medico-legal contexts, helping solicitors understand:

- what should be evident in nursing and care records,
- where evidential gaps commonly arise,
- and how fall-related decisions around supervision, restriction, and autonomy are later examined.

Designed to support early case assessment and evidential strategy, this eBook focuses on the real decision points that shape fall-related claims, not theory, but what the records reveal and what they often fail to show.



What Is a Fall?

Falls are one of the most frequent adverse events encountered in healthcare settings, but their prevalence often masks their complexity. For solicitors, falls cases rarely turn on the fact that a fall occurred; instead, liability hinges on what was known about the individual's risk, how that risk was assessed, and whether reasonable steps were taken to manage it.

Falls frequently sit at the intersection of multiple clinical issues - cognitive impairment, medication effects, mobility limitations, fluctuating capacity, and environmental factors. This makes them particularly vulnerable to fragmented assessment and inconsistent care planning, both of which are common features in litigated cases.

From a medico-legal perspective, falls demand scrutiny because their consequences can be severe.

What may initially appear to be a low-level incident can result in

fractures, intracranial injury, long-term loss of independence, or death. These outcomes significantly elevate both quantum and the evidential burden on defendants to demonstrate that risks were properly identified and managed.

Importantly, falls are not automatically negligent. However, they frequently expose gaps in documentation, failures to reassess risk in response to change, or an over-reliance on generic protocols that do not reflect the claimant's actual presentation. For solicitors, falls cases therefore offer a structured way to test whether care was proactive, individualised, and responsive - or whether risk management existed only on paper.

The Consequences of Falls

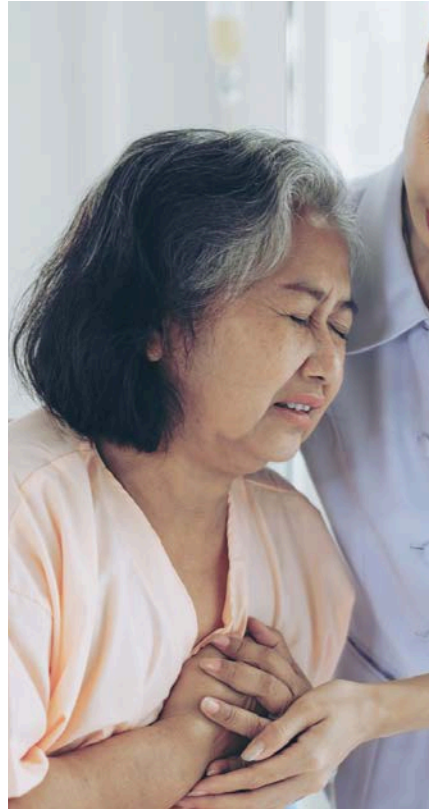
Falls cases often escalate not because of the incident itself, but because of the harm that follows. Outcomes can range from soft tissue injury through to fractures, head injury, intracranial bleeding, and death. These consequences frequently place falls at the centre of high-value clinical negligence claims and coronial investigations.

For solicitors, this makes early assessment critical. What initially appears to be a minor fall may later be linked to significant deterioration, prolonged hospitalisation, or fatal outcomes. Falls are regularly identified as the primary cause of death in both legal proceedings and inquests.

The increasing incidence of haematomas was also noted, particularly in patients receiving anticoagulation.

This underlines the importance of examining medication history and

wider clinical context when considering injury causation, foreseeability, and whether the harm suffered was a known and preventable risk.



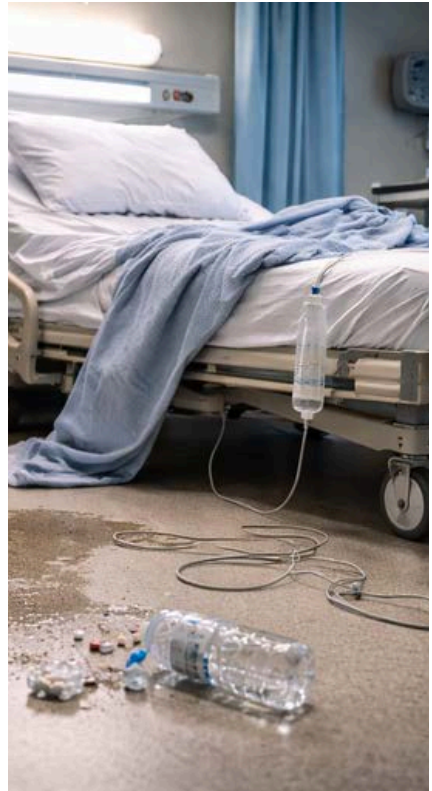
Environmental and Situational Risk Factors

Environmental and situational factors are often where falls cases are won or lost. Cluttered bed spaces, wet floors, poorly managed equipment, unsuitable footwear, and issues such as leaking wounds or incontinence can materially increase the risk of a fall if not actively managed.

For solicitors, these factors are particularly important because they are usually foreseeable and controllable. Unlike underlying medical conditions, environmental risks rely heavily on staff vigilance, supervision, and routine care standards. Failures in this area frequently expose weaknesses in basic nursing care, rather than complex clinical judgment.

The central legal issue is not whether a fall could have been prevented entirely, but whether reasonable and practicable steps were taken to reduce avoidable risk.

Where hazards were known, visible, or repeatedly documented, but not addressed, environmental factors can provide clear and compelling evidence of breach.



Falls From Height and Bed Rails

Falls from height are a recurring feature in serious injury and fatal claims, particularly in bed-based care. The use of bed rails is often central to these cases, not because they were absent, but because they were used without adequate assessment.

For solicitors, bed rails frequently raise questions of foreseeability and appropriateness. Where a patient lacks the cognition or capacity to understand their purpose, bed rails can increase risk rather

than reduce it, leading to climbing, entrapment, or higher-impact falls.

The key issue is that bed rails are not a default safety measure. Their use must be justified by reference to the individual's cognition, behaviour, and ability to manage risk. Where this rationale is missing or poorly documented, bed rail decisions often become a focal point for allegations of negligent risk management.



Identifying Falls Risk

The identification of falls risk is a foundational issue in many negligence claims. Organisations are expected to have systems that recognise when an individual is at increased risk, whether due to age, previous falls, impaired mobility, cognitive issues, or reduced awareness of danger.

For solicitors, the presence of a risk assessment is rarely the end of the enquiry. Visual indicators or standardised tools may show that risk was acknowledged, but they do not, in themselves, demonstrate safe care. The critical question is whether identification led to meaningful, consistent action.

Where records show that risk was recognised but not actively managed, reviewed, or translated into practical measures, this often exposes a gap between policy and practice.

It is this gap that frequently underpins successful arguments on breach of duty.



Risk of Injury vs Risk of Falling

Effective falls assessment goes beyond the likelihood of a fall occurring and must also address the potential severity of harm if it does. This distinction is particularly important in litigation, where the seriousness of injury often drives both causation arguments and quantum.

Factors such as reduced muscle strength, poor bone density, and age-related conditions including sarcopenia significantly increase the risk of fractures and serious injury. Where these

vulnerabilities are known or should have been known, the threshold for proactive risk mitigation is higher.

For solicitors, this analysis helps identify whether harm was foreseeable.

Where an individual was clearly at heightened risk of significant injury, a failure to adjust care accordingly may support arguments that the consequences of a fall were not only predictable, but preventable.



Diagnostic Assessment After a Fall



When a fall forms part of a patient's presentation, clinicians are expected to look beyond the event itself and consider why it occurred. Potential underlying causes may include infection, medication effects, cardiovascular instability, neurological disturbance, or blood pressure changes.

For solicitors, the diagnostic response is often a key evidential issue. Records should demonstrate that clinicians adopted a broad and reasoned approach, actively considering and ruling out relevant causes rather than treating the fall as an isolated incident.

Where this diagnostic process is absent, incomplete, or poorly documented, it may indicate a failure to meet an appropriate standard of care. Such gaps frequently strengthen arguments that subsequent harm was foreseeable and avoidable had the underlying cause been properly identified.

Medication and Falls Risk

Drugs that affect cognition, balance, or blood pressure, as well as interactions between medications, can materially increase the likelihood of a fall and the severity of resulting harm.

For solicitors, the focus is often on whether medication-related risks were actively reviewed rather than passively accepted. Records should show that a medication review took place, that potential risks were

recognised, and that decisions to continue treatment were clinically justified.

Where increased risk was knowingly accepted, the webinar emphasised the importance of clear, documented shared decision-making. The absence of this evidence can weaken a defence and support arguments that risk was neither properly assessed nor lawfully managed.



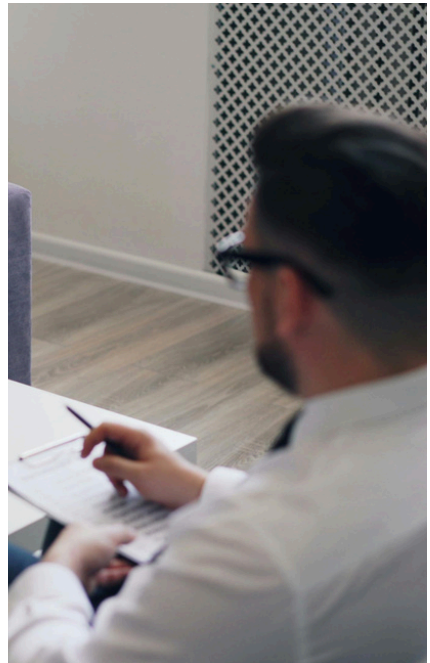
Mental Capacity and Risk-taking

Mental capacity is a key issue in many falls cases and often underpins arguments about personal responsibility and foreseeability. While patients with capacity are entitled to take risks, including unwise ones, this applies only where they understand and accept the potential consequences. In falls cases, this includes an appreciation of both the likelihood of harm and the seriousness of the outcome.

For solicitors, the central issue is evidential. Capacity is decision-specific and time-specific and cannot be assumed. Records should show that capacity was assessed at the relevant time, that risks were clearly explained, and that the patient made an informed decision.

Where capacity may have been affected by factors such as delirium, dementia, infection, medication, pain, or substance use, this assessment becomes particularly important.

Where increased risk was knowingly accepted, documentation should record not just the conclusion that capacity was present, but the reasoning behind it. In the absence of clear, contemporaneous records, assertions that a patient “chose to take the risk” are often difficult to sustain and may significantly weaken the defence.



Supervision, Observation and Liberty

Observation is commonly used as a means of managing falls risk, but it does not eliminate risk altogether. Human factors, competing clinical demands, and environmental constraints mean that falls can still occur even where supervision is in place. As a result, the presence of observation alone is not determinative of whether care was reasonable.

For solicitors, the central question is whether the level of supervision was appropriate, proportionate, and effectively managed considering the individual's assessed risk. Inadequate observation may indicate failures in risk mitigation, while overly restrictive measures may raise concerns around unnecessary restriction of liberty or potential deprivation of liberty, particularly where less restrictive options were available.

Clear and contemporaneous documentation is essential

Records should demonstrate how decisions about supervision were reached, how safety and independence were balanced, and why a particular level of observation was considered necessary and reasonable at the relevant time.

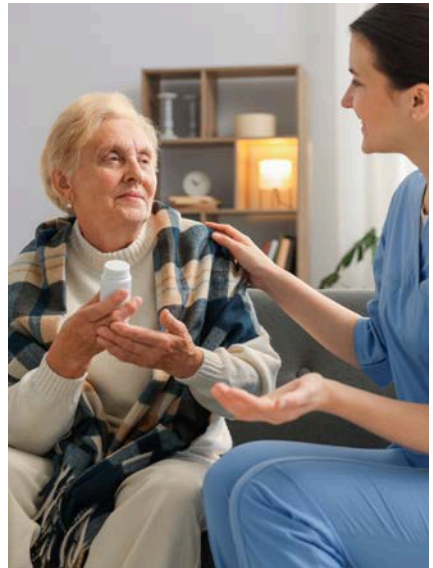


Care Planning and Documentation

Care planning is often central to falls litigation and frequently determines whether care is viewed as proactive or reactive. Effective care plans should demonstrate clear, rational clinical thinking and provide sufficient detail to guide day-to-day care in response to identified risks, behaviours, and vulnerabilities. They should reflect the individual's presentation rather than relying on generic or template wording.

For solicitors, poorly constructed care plans are a common evidential weakness. Where falls risks are identified but not translated into specific, proportionate actions, or where care plans remain unchanged despite deterioration or repeated incidents, this often undermines the defence. Such gaps may suggest that risk management existed in theory but was not meaningfully implemented in practice.

Clear, responsive documentation remains one of the strongest indicators of whether falls risk was actively managed. Care plans that are regularly reviewed, updated, and aligned with ongoing assessments are more likely to demonstrate defensible care than records that simply acknowledge risk without evidencing a structured response.



Managing Change and Deterioration

Falls risk is not static and should be reassessed as a patient's condition changes. Deterioration in cognition, mobility, medical status, or behaviour can materially alter risk and should prompt timely review and adjustment of care. Reliance on an initial assessment without ongoing evaluation may fail to reflect a patient's evolving presentation.

For solicitors, the focus is on whether documentation demonstrates active responsiveness to change rather than continued reliance on fixed assessments or tick-box tools. Where records note deterioration, repeated incidents, or emerging concerns but risk management measures remain unchanged, this often points to a failure in ongoing clinical judgment rather than an isolated oversight.

Consistent review and timely reassessment are key indicators of defensible care. Records that show risk was regularly reconsidered and management adapted accordingly are more likely to demonstrate that emerging risks were identified and addressed, rather than overlooked.



Responding When a Fall Occurs

The response to a fall is often as significant as the events leading up to it. Prompt assessment of injury, neurological status, and overall medical stability is essential, particularly where there is a risk of head injury or fracture. Appropriate manual handling techniques should be used where injury is suspected, and records should reflect a structured and reasoned clinical response.

For solicitors, the post-fall review is a key evidential stage.

Documentation should always demonstrate that the incident was analysed to identify potential causes and to assess whether existing risk management measures were adequate. Where a fall occurs but care continues unchanged, or where no review is evident, this may indicate a missed opportunity to mitigate further risk and prevent subsequent harm.



Key Takeaways and Conclusion

Fall-related injury claims rarely turn on a single issue. They often require coordinated insight across nursing standards, care delivery, functional impact, and rehabilitation planning. Understanding how these disciplines interact, and where evidential gaps commonly arise, is critical to progressing cases efficiently and proportionately.

How INNEG Supports Solicitors

INNEG supports solicitors with access to a broad, multidisciplinary panel of Care, Occupational Therapy, and Nursing experts, alongside the wider clinical and rehabilitation disciplines frequently required in fall-related and care-based injury claims. Our panel is structured to help solicitors avoid delays, control unrecoverable costs, and instruct the most appropriate expert from the outset, whether the issue centres on risk assessment, supervision, functional loss, or long-term care needs.

If you or colleagues are currently managing fall-related, nursing, or care-based injury cases and would benefit from timely access to specialist expertise, we invite you to explore how INNEG can support your case strategy.

Search our expert panel [here](#).

