Barking, Havering and Redbridge
University Hospitals
NHS Trust

Trust Headquarters
Queen's Hospital
Rom Valley Way
Romford
RM7 0AG

[redacted]

Date: 5 December 2025

Private and Confidential
Mr Graeme Irvine
East London Coroners Court
Queens Road
Walthamstow
London
E17 8QP

Subject: Response to Regulation 28 Report – Prevention of Future Deaths
In the matter of: Mr Mohan Hothi

Dear HM Coroner,

Thank you for your Regulation 28 Report dated 14 October 2025 regarding the tragic death of Mr Mohan Hothi. We appreciate the clarity of the concerns you have raised and fully recognise the importance of ensuring that lessons are identified and acted upon to reduce the risk of future harm. The Trust is committed to learning from patient safety incidents and to maintaining a system of continuous improvement across Queen's and King George Hospitals. We have carefully reviewed the matters you highlighted and set out below our response to each concern and the actions taken to reduce the risk of future harm or death.

The concerns identified:

During the course of the inquest the evidence 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. The matters of concern are as follows:

The patient died in hospital on 28 March 2025 due to injuries sustained in a fall at home in the early hours of the morning. During a previous hospital admission beginning in February 2025 and concluding on 20 March 2025. The patient sustained injuries in two separate unwitnessed falls,

these injuries were serious (one requiring surgery) but could not have been said to have contributed to his death. The two separate incidents were not assessed by the Trust as worthy of investigation through the Patient Safety Framework. This omission gives rise to a concern that future deaths may follow due to an inability on the part of the Trust to identify, reflect upon and remediate sub-optimal practice.

Evidence provided by the Trust at inquest to identify that reflection and remediation had been undertaken was vague and incomplete

The Trust's response:

Background and incident review process

Mr Hothi was admitted to Queen's Hospital from 21 February 2025 to 20 March 2025. During this admission Mr Hothi experienced two falls. The first occurred on 25 February 2025 while he was receiving care on the Queen's Frailty Unit; this incident was reported under reference 547827. The second fall occurred on 15 March 2025 while Mr Hothi was on Clementine B Ward and was reported under reference 549722. All inpatient falls, along with other patient safety incidents recorded on the Trust's reporting system, are subject to thorough investigation.

The circumstances surrounding both falls were similar. Mr Hothi had a significant history of recurrent falls in the community prior to this admission, which was precipitated by a fall at home in February 2025 resulting in an acute-on-chronic subdural haematoma. The causes of his falls were multifactorial, primarily associated with advancing age and a history of excessive alcohol intake. Falls prevention is addressed proactively within the Geriatrics Care Group, where patients are managed daily due to their inherently high risk of falling.

The investigations conducted under incident reference numbers [redacted] concluded that both falls were unpreventable. Mr Hothi was assessed as having full mental capacity, displayed no signs of confusion, and was able to understand and follow instructions. Under these circumstances, patients are not provided with constant supervision, as they are deemed capable of communicating their care needs to the nursing staff. Moreover, continuous supervision would require the implementation of a Deprivation of Liberty Safeguards (DoLS) authorisation, for which Mr Hothi did not meet the criteria.

The first fall, which occurred in the Queen's Frailty Unit, took place while Mr Hothi was using the toilet. In accordance with standard practice and in respect of Mr Hothi's privacy and dignity, staff left him alone at his request. The second fall, which occurred on Clementine B ward, took place during nursing handover, when Mr Hothi attempted to mobilise independently without requesting assistance.

In accordance with the Patient Safety Incident Review Framework (PSIRF) and the Trust PSIRF plan, incidents are referred for a learning response when the contributing factors are not well understood or when there is potential for significant local or organisational learning. Following the review of incidents [redacted], it was determined that the underlying factors were clearly understood – specifically that Mr Hothi chose to mobilise independently without awaiting assistance from nursing staff.

Local learning was identified in relation to the quality of the post fall action plan for incident [redacted] This learning point was to be addressed with the relevant nurse as part of their ongoing professional development and reflective practice.

Receipt of inquest notification

The Trust had a further opportunity to review the circumstances surrounding Mr Hothi's falls following receipt of the inquest notification on 06 June 2025, when a new incident ([redacted]) was raised in relation to Mr Hothi's death on 28 March 2025. The Therapy and Geriatrics Teams presented Mr Hothi's care at the Trust Incident Oversight and Learning Group (IOLG) meeting on 10 June 2025, where the circumstances of his falls, along with all aspects of his medical, nursing and therapy care were reviewed and discussed. The multidisciplinary review concluded that no further learning response was indicated.

This review process was repeated when the Geriatrics Team presented Mr Hothi's case at the Trusts' Coroner's Care Review Meeting (CCRM) held on 15 September 2025 and again on 29 September 2025. On both occasions, it was determined that no additional learning response was required.

The rationale for concluding that further investigation or learning was not indicated is outlined below:

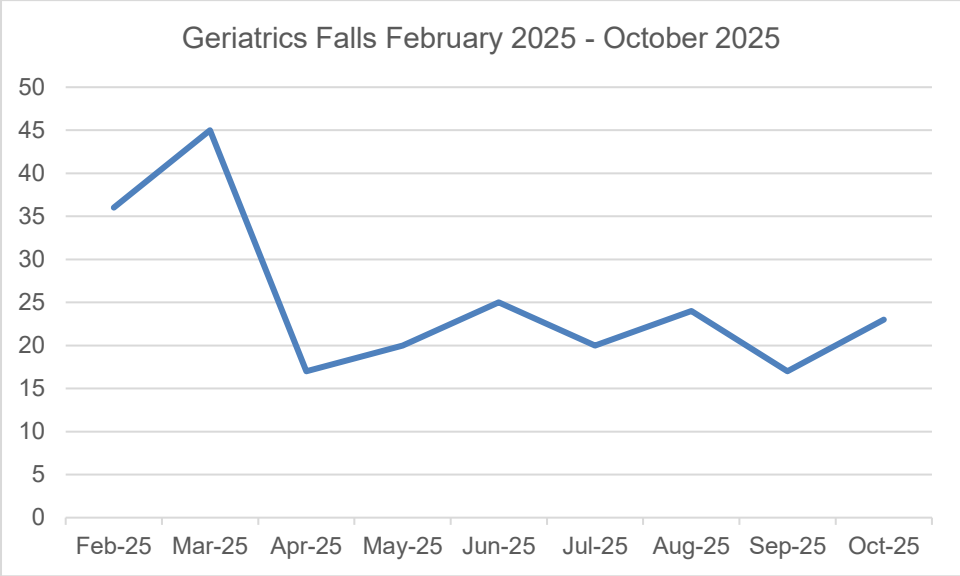
- Mr Hothi's inpatients falls were deemed unpreventable
- The factors contributing to Mr Hothi's falls were known and understood; therefore, no further investigation was required. Ongoing actions to manage these factors were already in place.
- No incidents occurring during Mr Hothi's hospital admissions were found to have caused or contributed to his death.

The Patient Safety Incident Review Framework (PSIRF) enables the Trust to review incidents across multiple wards and departments to identify trends and themes, allowing for the implementation of system-wide actions to reduce the risk of harm, rather than focusing solely on individual incident investigations or producing written report-style reviews.

Falls management in 2025 and action taken

This approach proved particularly valuable to the Geriatrics Care Group in 2025, as during February and March 2025, there was a noted increase in the number of inpatient falls reported across wards and departments, exceeding the usual baseline. Mr Hothi's falls on 25 February 2025 and 15 March 2025 were included within this period of increased reporting.

The reported number of falls during 2025 was as follows:



In February 2025, a total of 36 falls were reported, increasing to 45 falls in March 2025, compared with an average of approximately 25 falls per month in the Geriatrics Care Group. In response to this rise in falls and the associated risk of serious patient harm, the Head of Nursing and The Quality and Safety Advisor in Geriatrics implemented an action plan to address and monitor the situation. This action plan included the following measures:

1. The Head of Nursing reviewed the post-fall action plan on the ward with the nursing team for every reported fall to ensure appropriate assessments were in place and to maintain patient safety, reducing the risk of further falls.

2. Every reported fall incident is discussed at the weekly Geriatrics Care Group incident review meeting, chaired by the Quality and Safety Advisor, to determine preventability, assess any harm sustained and share learning across the Care Group.

3. During the weekly incident review, the Team also evaluated whether any incidents required escalation to the Trust's Harm Free Care Incident Oversight Group to determine the need for a wider learning response. This is required when the factors that caused the fall are not well understood.

4. All inpatient falls within the Geriatrics Care Group are reported to the Trust's Quality Governance and Steering Group (QGSG), with any falls resulting in serious harm detailed. Decisions regarding escalation for a learning response are formally recorded and reported to the Trust Board.

5. Ongoing communication and support from the Trust Falls Lead is provided to identify training needs which are subsequently implemented across the Care Group.

Since the implementation of these actions, the Geriatrics Care Group has observed a reduction in hospital falls, with reported figures occasionally reaching a record low of 17 falls in both April 2025 and September 2025 across 10 inpatient wards with a bed base of approximately 320 patients. The last instance of a patient sadly dying as a result of an inpatient fall in the Geriatrics Care Group occurred in 2022. The review and management of falls within this Care Group has been effective since that time. When an increase in the number of reported falls above the expected levels was observed earlier in 2025, targeted action was taken across all Geriatrics wards and departments at Queen's Hospital and King George Hospital to mitigate the risk of harm to patients.

The Trust acknowledges, however, that the level of detail regarding these actions and the effectiveness of falls management was not communicated to you prior to Mr Hothi's inquest. We apologise that the information you received did not adequately demonstrate the Trust's robust approach to managing falls.

Further action to be completed

To build on the work already undertaken and further reduce the risk of patient harm from inpatient falls, the Quality and Safety Team plans to commence observational audits on all wards and departments in the Geriatrics Care Group during December 2025 and January 2026. These audits will document the time taken for nursing staff to respond to patient call bells. Currently, there is no automated mechanism to record the interval between a call bell being pressed and a staff response, so this data will need to be collected manually. The purpose of these audits is to identify any delays in providing patients with assistance, particularly when mobilising to the toilet, and to inform further action if necessary to improve the timeliness of care.

These audits will be conducted covertly, without the nursing staff being informed in advance, to ensure that the data reflects actual response times and provides an accurate assessment of patient care delivery. The Trust would be grateful if, should you choose to publish this report, you could redact this paragraph and the preceding one to preserve the integrity and effectiveness of the audit.

The Trust has taken the issues identified by the Learned Coroner very seriously and has taken positive action to address those issues.

I would be happy to meet you to discuss this response if that would be helpful.

Yours sincerely,

[redacted]
Chief Executive