



**MR GRAEME IRVINE
HIS MAJESTY'S CORONER
EAST LONDON**

East London Coroner's Court, Queens Road Walthamstow, E17 8QP
[REDACTED]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

[REDACTED]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [REDACTED] CEO Barking, Havering and Redbridge University Hospitals NHS Trust [REDACTED] [REDACTED]
1	CORONER I am Graeme Irvine, Senior Coroner for the coroner area of East London
2	CORONER'S LEGAL POWERS 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 3rd April 2025, this court commenced an investigation into the death of

	Mohan Singh Hothi aged 76 years. The investigation concluded at the end of the inquest on 14/10/25. The court returned a short form conclusion of accidental death. Mr Hothi's medical cause of death was determined as; 1a Traumatic Subdural Haemorrhage Following a Fall
4	CIRCUMSTANCES OF THE DEATH Mr Mohan Hothi was admitted to hospital on 28th of March following a fall at home. He was found to have a catastrophic subdural haematoma with midline shift. Mr Hothi was not assessed to be a suitable candidate for surgery, he died later that day.
5	<u>CORONER'S CONCERNS</u> 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: 1. Mohan Singh Hothi died in hospital on 28th 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 20th March 2025 Mr Hothi sustained injuries in two separate unwitnessed falls, these injuries were serious (one requiring surgery) but could not be 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. 2. Evidence provided by the Trust at inquest to identify that reflection and remediation had been undertaken was vague and incomplete
6	ACTION SHOULD BE TAKEN 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.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 18th December 2025. I, the coroner, may extend the period.

	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.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the family of Mr Hothi, to the Care Quality Commission, NHS England and to the local Director of Public Health who may find it useful or of interest. 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 other 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. He may send a copy of this report to any person who he 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.
9	Dated: 14th October 2025 Signed: