St George's, Epsom and St Helier
University Hospitals and Health Group
St George's Hospital
Blackshaw Road
London
SW17 0QT
[redacted]

Prof. Fiona Wilcox
H.M. Senior Coroner for Inner West London
Westminster Coroner's Court

5 January 2025

Dear Professor Wilcox

I write in response to your Regulation 28 Report to Prevent Future Deaths, addressed to St George's University Hospitals NHS Foundation Trust, dated 12th November 2025, following the inquest into the sad death of Barry Clive LOXSTON on 30th July 2023.

In this letter you raise six matters of concern for the Trust to address, which I have set out below:

1. That poor patient handling and allowing patients to lie for hours in their own excrement is detrimental to patient wellbeing and may contribute to deaths.

2. That leaving medication with patients for them to take in their own time rather than supervise the taking of medication by the patient causes drug maladministration issues that may cause or contribute to deaths of patents.

3. That lack of investigation of the matter outlined in 2 increases the risk to patients of the concern outlined in 2.

4. That all relevant blood tests, including albumin level since low albumin may be associated with significant post operative complication risk, are not reviewed prior to surgery and considered as part of the risk/benefit analysis of surgery and the consenting process.

5. That there is no system mandating suitability to remain on the transplant list by the local nephrologist at each nephrology review.

6. That there is no system recommending direct contact with the local on call nephrology team by the transplant team to check whether there are clinically relevant matters in relation to the patient and their suitability for transplant that the local team are aware of and the transplant team are not, such as active other chronic illness or abnormal test results.

Matter 1:
For patients to be left for any length of time in soiled bedding is below the standards of care and dignity we want for all our patients, and we are sorry for this poor experience. A significant amount of work has been done to maintain consistent quality standards on Champneys Ward since the time of these events.

Champneys ward is a nineteen bedded, acute transplant ward. At the time of Mr Loxston's admission there was a 25-31% vacancy within the nursing establishment, with turnover at almost 17%. Following a recruitment campaign, the nursing team is now fully substantiated, with a turnover of 0% for last 6 months, and has new leadership in place, with a new Head of Nursing and Matron appointed in 2024 and 2025 respectively.

As part of a quality improvement cycle, learning from incidents and patient feedback, the Head of Nursing and Matron are using audit to ensure that all quality metrics are met, and gaps are addressed immediately. Our quality observatory audit covers a range of areas, including manual handling risk assessments, pain scores, patient experience, pressure ulcer care and responsiveness to call bells. Staff are now 100% compliant with their manual handling training on the ward, and should a patient require moving with a fracture or disability, these needs are discussed daily as part of the multidisciplinary board rounds, with appropriate advice and guidance given for safe patient handling.

With consistency and a continuous improvement cycle we remain focused on quality of care, patient safety and patient experience.

Matter 2:
Our Trust Medicines Management Policy makes clear the standards and practice nursing staff are expected to follow, including the need to ensure each patient takes medication given and medications are not left with the patient to take later. However, it is acknowledged that there were gaps in medicines management practice at the time of Mr Loxston's death.

A summary audit of medication safety incidents identified lapses in practice, competence and knowledge. In 2023 the ward medication safety audit, looking at all aspects of medication administration, scored between 76%-88%. A medication safety meeting was called in 2024 by the Head of Nursing, following review of medication safety and incidents involving medication administration across the Renal Haematology and Oncology directorate. Following this, significant training was put in place.

The training was delivered in bite size sessions by the nursing and pharmacy teams across the directorate to educate staff on the ten rights of medications. It also referred to the NMC code of conduct and the role of the nurse in administering medications. The purpose of the training was to ensure all staff were aware of the processes required for safe administration and that failure to follow the correct process in medications administration was deemed a lapse in the NMC code of conduct and the Trust Medicines Management Policy. The team continued to provide this teaching until all members of staff had received the update. Staff new to the Trust undergo medicines management training as part of their induction process. This involves a drug calculation test, with a competency 'passport' and practical assessment before being able to administer medicines within the Trust.

Reviewing the corresponding audit in 2025, improvement can be seen, with scores ranging between 91%-100%. As part of the auditing process, the auditor now speaks to patients regarding patient experience and care within the ward and feeds this back to the ward team to understand and improve patient experience of medications. This process will be continued within the Directorate to ensure we remain focused on medication safety.

Matter 3:
It is acknowledged that there was a lack of investigation and a lack of process in the management of medication safety incidents across the directorate. It is also acknowledged that there was a culture of under reporting incidents and, therefore, investigations that should have taken place did not. Since March 2024 the care group has seen a rise in incident reporting, especially near miss incidents. This is believed to be due to the changes in culture and education; incident reporting is widely welcomed by the senior team and all incidents are reviewed and fed back to the reporter.

Historically, incidents have been discussed at the Renal Care Group meetings. It has been recognised that there was a need for a separate Joint Renal Governance meeting, where the full multidisciplinary team comes together to focus on quality, risks, patient safety and patient experience. This will start in January 2026 and run monthly. The Division has also fully implemented the Patient Safety Incident Response Framework (PSIRF) since July 2024 and, as part of this, a weekly Divisional Incident Review Group, chaired by the Clinical Chair, reviews incidents within each area and looks for themes and opportunities for learning and improvement. This allows much more flexibility to review and understand areas of concern and provides a robust governance and escalation process to support directorates and care groups to take action and ensure improvements are embedded.

The Trust runs a ward accreditation programme; a Trust wide internal inspection team supports areas to align their services to Trust standards and CQC quality statements. The aim is to recognise good practice and improve areas that require attention, using a pre-agreed set of questions to assess quality metrics. Champneys ward was rated bronze in 2022, but the improvement work described has led to a gold rating being awarded in 2025. Medicines management is also reviewed as part of the accreditation assessment. In July 2023 the ward scored 83% in this domain. This has risen to 93% in 2025, aligning with the improvements seen in the ward-based quality observatory audits.

Matter 4:
The common surgical practice at the time of the incident was to review blood tests relevant to fitness for acute transplantation. Other tests, although reviewed, were not considered as absolute contraindications to transplantation because it was the understanding that once the patient was on the active transplant waiting list, they were seeing a nephrologist and being monitored for general health and fitness.

According to Kidney Disease: Improving Global Outcomes [KDIGO] and European Renal Best Practice (ERBP) Guidelines, hypoalbuminemia is not an absolute contraindication for acute transplantation. However, since hypoalbuminemia is known to affect outcomes from surgery generally, we will be including it in our peri-operative assessment in future to contribute to risk and benefit analysis of transplantation. Where there is an unknown cause of hypoalbuminemia or chronically low albumin with known cause, these patients will be suspended on national waiting lists and will only be reactivated once all investigations are complete and patients are stable to be reactivated. These patients will be monitored by the patient's nephrologist and, in cases with multiple comorbidities, will pass through the transplant MDT before activation on the national waiting list.

In addition to the above measures which will address the pre-transplant activation process, since this incident there has been a change in unit practice to review both acute and historic investigations and to better consider general fitness for surgery, including discussion with the base hospital nephrologist. The results of all requested tests are considered in the risk/benefit analysis of surgery and in the consenting process. Since the average waiting time for transplant is 3.5 years, and once an offer is deemed not suitable for transplant irrespective of recipient and donor issues, there is no guarantee when the next offer will come, it is important that risk assessments are timely and balanced. The consent covers the benefit of renal transplant, waiting time on the transplant list and its implications on overall health status of the patient, including the safe window for transplantation in certain patients, and the risk of transplantation, including risks related to low albumin levels such as poor wound

healing, tissue oedema and higher than average risk of peri-operative morbidity and mortality. This has been added to the existing pathway checklist (see appendix).

Matter 5:
The transplant unit at St George's performs transplant surgery for patients whose primary nephrology care is under St George's Trust but also for the unit at Epsom St Helier University Hospitals NHS Trust and University Hospitals Sussex NHS Foundation Trust. Mr Loxston was under the care of the nephrology unit at St Helier Hospital and, therefore, the matters of concern were shared with them, and they have worked with us in responding to this report.

In line with national policy, we are transplanting higher risk patients with more co-morbidities. For this group of patients, in most cases, kidney transplantation offers better survival and quality of life compared to staying on dialysis. However, we acknowledge this means our practices need to be reviewed regularly to ensure we are able to manage the risks associated with this. There is a comprehensive pathway for patients to be activated and then kept active on the list. Once patients are activated on the list, they should be regularly reviewed by a nephrologist on a three-to-four-month basis. In addition, all three units hold a monthly review meeting in which all patients on the transplant waiting list are reviewed to ensure they remain active on the list.

We conducted a retrospective audit at St George's from May 2023 to June 2024. We reviewed 31 patients who were active on the transplant waiting list. We found that 85% (89/105) of patients had a nephrologist review their suitability during their regular 3-monthly review. A similar audit was carried out at St Helier, where a retrospective audit confirmed that for patients active on the transplant list, 96% (186/193) had been reviewed by a nephrologist within the last 4 months. These audits have shown that there is room for improvement. We have shared the outcomes of these audits with all three centres. Our aim is to achieve 100% of patients to be reviewed for their suitability for transplant at nephrology clinics and we will continue to regularly audit and monitor this.

Following the audits it has been agreed across all three nephrology units that a statement regarding fitness to remain active on the transplant list will be explicitly recorded at each clinic review. We have added a row in all nephrology letters about transplant status to ensure the nephrologist has reviewed all patient investigations and they are happy for the patient to remain active on the list.

All three units have an existing structure to review their cohort of waitlisted patients on monthly basis and ensure that clinical reviews are up to date. At St George's it happens on a fixed day of the month. At St Helier and Brighton these meetings are sporadic. The learning from this incident has helped to streamline these to have a fixed day of every month to review all patients in an MDT. The outcome of this is recorded in a templated document. The transplant coordinators make sure that patients are appropriately activated or suspended after these MDT meetings.

NHS Blood and Transplant (NHSBT) monitor short-term patient outcomes following organ transplantation through centre specific cumulative sum (CUSUM) analyses. These are undertaken quarterly for kidney transplantation. These 'within centre' analyses enable prompt detection of any changes in failure and mortality rates, providing external assurance and enabling centres to compare current outcomes with their own past performance to assist in internal auditing of outcomes following organ transplant. Mr Loxston's case was reviewed as part of these processes at a quality visit in 2025, and this has also supported us to learn from his death and ensure we implement changes to reduce the risk of poor outcomes for similar patients. In addition to the measures described above, we are revising our annual surgical review of all patients waiting on the national transplant waiting list. Previously this was offered to patients over 70, with high BMI, with Autosomal Dominant Polycystic Kidney Disease, or with multiple comorbidities. After this incident we have lowered our age cut off to patients above 50 years. We are also in the process of developing new agreements with St Helier and Brighton to run annual surgical review clinics. In this way, we aim to ensure we have better oversight of the fitness of all patients waiting for transplant.

Matter 6:
There is a revised pathway that outlines the actions required when a kidney offer is received for transplant. This states that contact should be made with various teams, including the nephrologist at the base hospital. We have added multiple points along the pathway to ensure that communications are made appropriately and built in regular audit to provide assurance of the effectiveness of these processes (see appendix).

In addition, now that the same electronic patient record system at St George's has been adopted at Epsom and St Helier, access to patient records will be shared across the sites. This cannot be rolled out for Brighton, however the revised pathway acts to ensure robust handover of information.

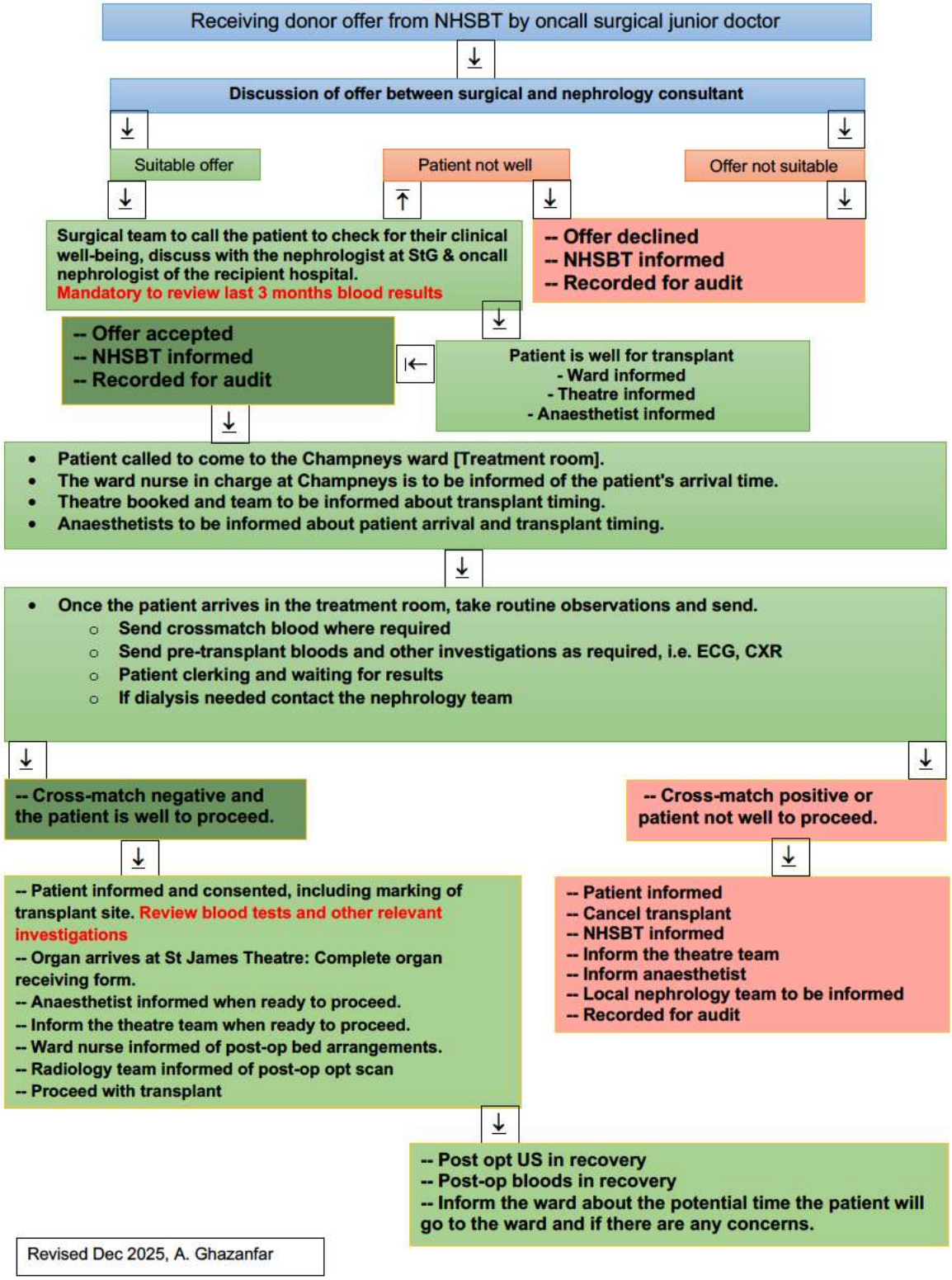
I thank you for providing this Prevention of Future Deaths report. The renal teams across gesh and the renal transplant team have taken on board all the issues that have been raised. A more robust quality management system for the transplant program is being formalised, looking at critical steps which can directly affect patient experience and outcomes and embedding a system of regular audits and monitoring to ensure these steps are adhered to.

Yours sincerely,

Interim Group Chief Executive Officer
St George's, Epsom and St Helier University Hospitals and Health Group (gesh)

Appendix:

Summary of the deceased donor renal transplant pathway



Revised Dec 2025, A. Ghazanfar