REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Secretary of State for Health and Social Care, 39, Victoria Street, London. SW1H 0EU
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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.
3	**INVESTIGATION and INQUEST** On 2nd December 2025 evidence was heard in two inquests touching the deaths of : 1. **Dr Debapriya Ghosh**, who had died at St George's Hospital on 11th February 2024 aged 83 years. **Medical Cause of Death** Ia Subdural haemorrhage Ib Traumatic Head Injury II Ischaemic heart disease. **How, when and where the deceased came by his death.** Dr Ghosh was admitted to St George's Hospital on the morning of 9th February 2024. The A&E department was exceptionally busy. He was initially cared for in the corridor and did not transfer to a cubicle until early evening. He was frail, suffering with delirium, electrolyte imbalance, infection and a type II myocardial infarction. He was not risk assessed by the nursing staff until almost midnight. In the early hours of the morning of 10/2/2024 his delirium and agitation increased such that medical advice was sought. However his nursing risk was not reassessed, and he should have been escalated for 1:1 care. At around 08:30 he had an unwitnessed fall and sustained a significant head injury that directly led to his death at 16:27 11/2/2024. If he had been allocated appropriate nursing supervision his death would have been avoided. **Conclusion of the coroner as to the death:** Accidental fall contributed to by a failure to provide appropriate nursing supervision.

2. **Mr David Albert Ward** who had died at St Goerges Hospital on 10th February 2024 aged 76 years.

Medical cause of death:

1a Subdural Haemorrhage
1b Traumatic Head Injury

II Non-Hodgkin Lymphoma

How, when and where the deceased came by his death

Mr Ward was admitted to St George's Hospital with frailty, confusion and likely infection on 7/2 /2024. On 12/1/2024 he had emergency surgery in Poole for colonic lymphoma. Due in part to acuity in A&E he received no nursing risk assessments and following his daughter leaving at approximately 02:30 8/2/2024 received no significant nursing care. He was found kneeling by his bedside having suffered a head injury which led to and caused his death on 10/2/2024 at 13:45.

His nursing risk was such that he should have received enhanced care and if he had done so the fall and his death would have been avoided.

Conclusion of the coroner as to the death.

Accident contributed to by neglect.

4 **Evidence Relevant to the Matters of Concern:**

Extensive evidence was taken from the families, nurses, doctors and pathologists.

In each case it was clear that due to patient acuity there was insufficient resource in terms of cubicles and bed spaces and insufficient nursing staff to manage the demand in the department.

In each case frail elderly men were left to wait for very many hours being cared for by their families, rather than supported by nurses and treated in proper bed spaces. When their families left during the night, they both fell as they were unsupervised, sustaining injuries that led to their deaths.

Since the deaths St Georges Hospital has put in place systems to try and allocate more nurses to A&E, divert frail patients to an elderly care unit, train and audit on risk assessments and make available health care assistants to help care and monitor patients who need 1:1 care amongst other matters.

	However evidence was taken during the inquest of Mr Ward that despite all these measures many shifts in A&E are still exceptionally busy and feel little different to how they were back in Feb 2024. This was clearly causing distress to the staff attempting to manage impossible situations where demand clearly exceeds available resource in terms of staff and facilities.
5	**Matters of Concern** 1. That St George's Hospital and other hospital A&E departments have insufficient staff to manage demand during busy periods such that nursing risk cannot be managed without relying on families. 2. That at work stress on A&E staff due to staff and resource shortages may cause them to leave the profession exacerbating shortages of experienced staff and thus increase risks in A&E. 3. That local hospitals such as St George's have implemented multiple actions within their power to attempt to manage demand and risk, but these have been insufficient such that risk remains, and so central consideration should be given to the issues. 4. That it is unsafe for families to leave their loved ones unsupervised in overcrowded A&E departments.
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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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 following Interested Persons: [redacted] Interim Group Chief Executive Officer, St George's University Hospitals, NHS Foundation Trust, Blackshaw Road, London.

	SW17 0QT [redacted], 57, Queen's Road, Wimbledon, SW19 8NP [redacted], 30, Gap Road, London. SW19 8JG I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.
9	**17th December 2025** [redacted] **Dr Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR** **Telephone:0207 641 8789.**