Kent and Medway Coroners' Service
Oakwood House
Oakwood Park
Maidstone
Kent
ME16 8AE
[redacted]

Date: 10 February 2026
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

The Secretary of State for Health and Social Care

Kent County Council

Medway Council

Kent and Medway Integrated Care board

1. CORONER

I am Catherine Wood Area Coroner for Kent and Medway

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 29 May 2025 I commenced an investigation into the death of Barbara Wingate. The investigation concluded at the end of the inquest . The conclusion of the inquest was

A narrative "She died as a consequence of injuries sustained following a fall contributed to by avoidable delays in diagnosing and treating her pelvic fractures."

1a Multiple Organ Failure

1b Hypoxic Cardiac Arrest with Aspiration

1c Multiple Fractures

1d Fall

II Ischaemic Heart Disease, Atrial Fibrillation, heart Failure

4. CIRCUMSTANCES OF THE DEATH

Barbara Wingate was a 71 year old woman with a past medical history of hypertension, atrial fibrillation and cardiac failure and was on anticoagulants. She fell at home on 18 May 2025 and an ambulance was called who took her to Medway Maritime hospital having pre-alerted the hospital and classifying her as a "silver trauma". She was seen in the emergency department just before midnight but there were no beds in the resuscitation department and she was instead taken to the Rapid Assessment Unit when she should have gone to the resuscitation department and a full trauma call initiated. She was assessed by a nurse but only seen by a doctor just after 01.30 am. An x-ray revealed some spinal abnormalities and the following morning around 08.30 she was in significant pain and pelvic imaging was suggested. She was admitted under the care of the medical team but the pelvic x-ray was not undertaken before she collapsed around 4 pm that afternoon. Imaging revealed multiple pelvic fractures and the major haemorrhage protocol was commenced. She suffered a cardiac arrest and was intubated and ventilated and a return of spontaneous circulation achieved. She was stabilised and transferred to Kings College Hospital around 22.00 by which time she was hypoxic and hypotensive despite inotropic support and intubation and ventilation. She was transfused with blood and blood products, stabilised and transferred to Intensive Care. She died on 21 May 2025 as a consequence of multiple organ failure due to hypoxic cardiac arrest with aspiration in turn due to bleeding and pain from her multiple fractures following her fall.

5. CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. -

Evidence heard at the inquest revealed that the resuscitation department where Mrs Wingate should have been admitted was full and the evidence indicated that this was and is almost a daily occurrence at the Trust. The court heard that the main issue is trying to discharge a patient to a suitable area in the hospital to free up a cubicle or bay in the resuscitation department. This in turn is due to beds being occupied by patients who are medically fit to be discharged. On any given day the court heard that up to a third of the hospital beds can be filled with patients who are fit to leave hospital.

The court heard that the main delay is in discharging patients to appropriate settings or placements and the Trust have taken all steps they can internally to improve the flow of patients through the hospital. From the evidence it would appear that those responsible for providing care in the community including both the social care providers and the community healthcare providers are not providing either timely appropriate care packages in the patient's home or a bed in an alternative placement be that a nursing home or residential home placement. The evidence suggested that where patients were self funding the delays in

discharge were less acute.

This means patients are kept in hospital for longer and thus are more at risk of contracting hospital acquired illness themselves which could lead to their own death but are also blocking beds which are needed to treat patients who require acute care. This is leading to patients being kept longer in the emergency department and reducing available space to receive new critically ill patients. Both of these options can lead to death as seen in this case and there is clearly a risk of death for others requiring clinical care in an acute hospital.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you are all 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 8 April 2026. 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 Mrs Wingate's family, Medway NHS Foundation Trust and Kings College Hospital NHS Foundation Trust.

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.

10 February 2026

Signature 

Catherine Wood Area Coroner for Kent and Medway