Barts Health
NHS Trust

Newham University Hospital
Glen Road
London
E13 8SL

Dear Mr Irvine,

Re: Regulation 28 Report to Prevent Future Deaths

Thank you for your Regulation 28 Report dated 25 February 2026, issued following the inquest into the death of Mrs Urmila Patel. On behalf of Barts Health NHS Trust, I would like to express our sincere condolences to Mrs Patel's family and acknowledge the seriousness of the concerns you have raised.
A detailed internal review has been undertaken to ensure the circumstances identified during the inquest are fully understood and that proportionate and sustainable actions are implemented to reduce the risk of similar events occurring in the future.

Following the inquest, the Trust has progressed regulatory referrals for the staff involved, in line with your request. These are being managed in conjunction with Workforce and Professional Standards teams to ensure they are undertaken in a timely, proportionate, and supportive manner, with learning identified to inform wider improvement. In parallel, the circumstances of this case have been reviewed through safeguarding processes, including referral to the relevant local authority and progression for consideration of a Safeguarding Adult Review. Oversight of these processes is maintained through Trust Workforce Governance and the Safeguarding Committee.

Below, I set out our response to each matter of concern and the actions taken.

1. Falls prevention and care planning

You raised concern regarding the failure to complete an adequate falls risk assessment on admission and the absence of a documented mobility or falls care plan.

The Trust acknowledges that falls risk assessment and care planning for Mrs Patel were not completed in line with expected standards. This represented a missed opportunity to identify risk and implement preventative measures at an early stage.

Actions taken

Targeted education has been delivered to nursing staff, focusing on the timely completion of falls risk assessments on admission, recognition of dynamic risk, and the importance of translating assessed risk into clear and practical care plans. This has been reinforced through ward-based teaching, safety huddles, and incorporation into local induction and refresher training.

Accountability has been strengthened through clearer expectations of ward leadership. Ward managers and nurses in charge are now required to review new admissions each shift to confirm that falls risk assessments and associated care plans have been completed, with prompt action taken where gaps are identified.

A programme of routine audit has been introduced to review both completion and quality of falls risk assessments and care plans. Findings are reviewed at ward level and escalated through Divisional Governance where required, with actions agreed, tracked, and re-audited.

Falls risk and mobility status are now explicitly discussed at shift handovers and safety huddles, supporting visibility across the multidisciplinary team and consistent application of preventative measures.

Falls prevention has also been strengthened through a multidisciplinary quality improvement programme, recognising the contribution of nursing, medical, therapy, and pharmacy teams. This includes initiatives focused on appropriate footwear, structured medication review (including medicines associated with increased falls risk), and consistent post-fall multidisciplinary review.
To support assurance, a ward-level falls audit programme commenced on 2 February 2026, with the most recent audit completed on 14 April 2026. Early findings demonstrate high compliance with falls risk assessment (97.2%), improved initiation of falls care plans (83.3%), improved completion of lying and standing blood pressure (78%), and timely medical review following falls. These findings are reviewed through ward and divisional governance processes to support sustained improvement.

Status: Implemented and embedded through education and governance oversight.

2. Failure to recognise and escalate following a fall and inadequate monitoring

You raised concerns that Mrs Patel's fall on 29 June 2025 was not recognised or escalated appropriately, and that monitoring and supervision were insufficient.

The Trust recognises that post-fall recognition, supervision, and escalation were not sufficiently robust and that this contributed to a delay in identifying deterioration risk.

Actions taken

A mandatory post-fall care bundle and checklist has been introduced for all inpatient falls. This ensures that each fall is managed as a clinical event requiring structured assessment and response, aligned to the Patient Safety Incident Response Framework.

The care bundle requires completion of defined immediate actions, including neurological observations, clear escalation triggers, and documentation within the clinical record. This is supported by standardised documentation prompts to promote consistency.

To strengthen escalation, a Red Flag Escalation Standard Operating Procedure has been developed and is being embedded. This provides clear triggers for escalation to medical teams and explicitly includes concerns raised by patients, relatives, or staff. This is supported by the implementation of Martha's Rule, enabling families to request urgent clinical review where deterioration is suspected.

Senior oversight has been enhanced through the introduction of an out-of-hours falls review protocol, requiring the Duty Matron or Site Manager to review all inpatient falls within two hours, providing assurance that appropriate actions and escalation have occurred.

Monitoring reliability has been strengthened through regular audit of post-fall neurological observations, with findings reviewed through divisional governance structures.
In addition, multidisciplinary simulation training has been introduced, using scenarios such as anticoagulated patients and neurological deterioration, to reinforce recognition of risk, escalation, and immediate management.

Status: Implemented and monitored through audit, senior clinical oversight, training, and governance oversight.

3. Clinical decision-making following the fall: head injury, CT imaging, and anticoagulation

You raised concerns regarding the failure to adequately assess the risk of intracranial bleeding, the absence of timely CT imaging, and failure to review anticoagulation.

The Trust accepts that clinical decision-making following the fall did not meet the expected standard, particularly given the known risks associated with head injury in anticoagulated patients.

Actions taken

A mandatory post-inpatient fall medical review care bundle has been implemented, supported by a standardised proforma. This provides a structured framework for clinical assessment and decision-making following a fall.

The proforma requires:

- Immediate neurological assessment, including Glasgow Coma Scale and delirium screening
- Consideration of intracranial injury and need for urgent CT imaging in line with NICE guidance
- Specific prompts relating to anticoagulated patients
- Mandatory review of medications, including anticoagulation, with clear documentation of decisions

The care bundle also requires review of recent clinical history and investigations to identify contributory factors and inform management.

Clear expectations are set regarding escalation to senior decision-makers where there is uncertainty or increased clinical risk.

Learning from this case has been shared through medical and nursing governance forums and reinforced through simulation-based training focusing on deterioration, imaging decisions, and anticoagulation safety.

Status: Implemented and embedded through mandatory documentation, training, and governance oversight.

4. Documentation, ward rounds, and communication

You raised concern that ward staff did not identify that Mrs Patel had fallen, reflecting gaps in documentation and communication.

The Trust acknowledges that these failures contributed to a lack of shared situational awareness.

Actions taken

The Trust has reinforced expectations that all inpatient falls and significant safety events are documented contemporaneously and clearly communicated during both nursing and medical handover.

All inpatient falls occurring out of hours or at weekends are now required to be included in formal medical handover processes, ensuring visibility to the parent clinical team at the earliest opportunity. Nursing handovers are required to explicitly highlight recent falls and ongoing monitoring requirements, supporting continuity across shifts.

Ward teams have been reminded that ward rounds and multidisciplinary reviews must include active consideration of events from the preceding 24–72 hours, including weekends.

Ward Managers and Nurses in Charge provide oversight of handover processes, with particular attention to events occurring out of hours.

Daily multidisciplinary board rounds have been strengthened through the MBRACE quality improvement programme, supporting structured review of patient risk, including falls and frailty, and improving shared situational awareness.

Compliance with these expectations is monitored through local governance processes and escalated where gaps are identified.

Status: Reinforced and monitored through leadership and governance oversight.

Summary and assurance

Barts Health NHS Trust recognises that the care provided to Mrs Patel did not consistently meet the standards expected, particularly in relation to falls prevention, post-fall escalation, clinical decision-making, and communication.

The actions described above represent a coordinated, system-level response aimed at improving the reliability of care, strengthening workforce capability, and enhancing clinical oversight and governance.

Progress is monitored through audit, training compliance, and divisional governance structures, with oversight provided through the Trust's Quality and Safety Committee. Where variation or gaps are identified, targeted actions are implemented and tracked to support continuous improvement.

These measures are intended to reduce the likelihood of similar events occurring in the future and to support safer, more consistent care for patients at risk of falls and deterioration.

Yours sincerely,

[redacted]
Medical Director

[redacted]
Group Chief Medical Officer