Department of Health & Social Care

[redacted]
Parliamentary Under-Secretary of State

39 Victoria Street
London
SW1H 0EU

[redacted]

Senior Coroner, Mr G Irvine
East London Coroner's Court
Queens Road, Walthamstow
E17 8QP

[redacted]

Dear Mr Irvine

Thank you for the Regulation 28 report of 26 February 2026 which you sent to the Secretary of State for Health and Social Care about the death of Urmila Patel. I am replying as the Minister with responsibility for Patient Safety.

I would like to begin by saying how saddened I was to read of the circumstances of Mrs Patel's death, and I offer my sincere condolences to her family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

Your report raises concerns that:

- Nurses did not conduct an adequate falls risk assessment for Mrs Patel.
- Nursing staff failed to create a care plan for Mrs Patel's mobility.
- Trust staff missed a fall on 23rd June 2025 and did not reassess fall risk.
- Nursing staff did not monitor Mrs Patel on the afternoon 29th June 2025.
- The Trust staff did not assess the risk of an intra-cranial bleed after Mrs Patel's fall on 29th June
- The duty doctor did not refer Mrs Patel for an urgent CT Head scan on 29th June 2025.
- The duty doctor did not review Mrs Patel's warfarin prescription post-fall.
- Ward staff failed to check previous clinical records during the ward round on 30th June 2025, missing the alert about Mrs Patel's fall on 29th June.

Given the concerns you have raised I feel it is important that you receive a response directly from NHS England as it has oversight for the issues you raise. Therefore, my officials have contacted NHS England who have agreed to respond to you directly about the Prevention of Future Death report concerning Mrs Patel.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,

[redacted]

PARLIAMENTARY UNDER-SECRETARY OF STATE
FOR HEALTH INNOVATION AND SAFETY