

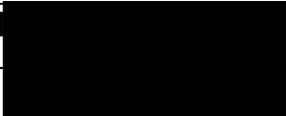


MR G IRVINE
SENIOR CORONER
EAST LONDON CORONERS COURT
QUEENS ROAD, WALTHAMSTOW, E17 8QP

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. [REDACTED], Chief Executive Office, Barts Health NHS Trust2. [REDACTED], Secretary of State for Dept. Health & Social Care
1	<p>CORONER</p> <p>I am Graeme Irvine, senior coroner, for the coroner area of East London</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p> <p>http://www.legislation.gov.Uk/ukpga/2009/25/schedule/5/paragraph/7</p> <p>http://www.legislation.gov.Uk/uksi/2013/1629/part/7/made</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 08/17/2025 this Court commenced an investigation into the death of Urmila Patel aged 78-years. The investigation concluded at the end of the inquest on 24/02/2026. The Court returned a short-form conclusion of "accident compounded by neglect".</p> <p>Mrs Patel's medical cause of death was determined as;</p> <p>1a Acute Subdural Haematoma</p>

4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Urmila Patel was a 78 year old woman who was admitted to Newham University Hospital (“NUH”) in relation to suspected sepsis on 10th June 2025. Mrs Patel was admitted onto Thistle ward, where appropriate falls risk assessments were not undertaken. No clear care plan was produced to address risks related to her mobility.</p> <p>On the afternoon of 29th June 2025, Mrs Patel sustained a fall whilst in the ward toilet. At the time of the fall, she was not being adequately supported by ward staff.</p> <p>In the immediate aftermath of the fall a medical review was sought, during which Mrs Patel’s son told hospital staff that his mother had struck her head. Despite his account, Mrs Patel’s warfarin medication was not discontinued, and no request was made for a CT scan of Mrs Patel’s head.</p> <p>In the days that followed Mrs Patel deteriorated and on Tues 1/7/25 another medical review was triggered due to Mrs Patel’s lowered consciousness and facial droop. At this stage an urgent CT head scan was undertaken which showed a significant subdural haematoma which was placing pressure on her brain, causing a midline shift. At this stage Mrs Patel’s warfarin was held, she was deemed not to be a safe candidate for neurosurgery. Mrs Patel died in hospital on 7th July 2025.</p>
5	<p>CORONER’S CONCERNS</p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows. -</p> <ol style="list-style-type: none"> 1. The failure of nurses on the ward to instigate an adequate falls risk assessment of Mrs Patel. 2. The failure of nursing staff on the ward to produce a meaningful care-plan for Mrs Patel’s mobility. 3. The failure of Trust staff to note a fall on 23rd June 2025 and reassess risk of falls. 4. The failure of nursing staff on the ward to monitor and supervise Mrs Patel on the afternoon of 29th June 2025. 5. The failure of Trust staff to adequately assess the likelihood of a traumatic intra-cranial bleed following the fall on 29th June 2025. 6. The failure of the duty doctor to act decisively and refer Mrs Patel for an urgent CT Head scan on 29th June 2025. 7. The failure of the duty doctor to review Mrs Patel’s warfarin prescription after the fall. 8. The failure of ward staff on the ward round on 30th June 2025 to read the clinical records from the previous day to alert them to Mrs Patel’s fall on 29th June 2025.
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely 24th April 2026. I, the coroner, may extend the period.</p>

	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	<p>COPIES and PUBLICATION</p> <p>1 have sent a copy of my report to the Chief Coroner and to the following Interested Persons the family of Mrs Patel, the Care Quality Commission, the GMC and the Nursing & Midwifery Council. 1 have also sent it to the local Director of Public Health who may find it useful or of interest.</p> <ul style="list-style-type: none"> • Mr Patel’s family • The Care Quality Commission • The Nursing and Midwifery Council • The General Medical Council <p>1 am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it.</p> <p>1 may also send a copy of your response to any other person who 1 believe may find it useful or of interest.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>[DATE] 26 February 2026 [SIGNED BY CORONER] </p>