



West London Coroner Service
25 Bagleys Lane, Fulham, London, SW6 2QA

Date: 1 April 2026

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: The Chief Executive, South West London and St George's Mental Health NHS Trust

cc The Chief Coroner

CORONER

1 I am **Richard Furniss, HM Assistant Coroner for West London**
CORONER'S LEGAL POWERS

2 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>

INVESTIGATION and INQUEST

On 11 October 2023 an investigation was commenced into the death of Lajos MANDRIK. The investigation concluded at the end of the inquest on 1 April 2026 . The conclusion of the inquest was Suicide contributed by Neglect and the jury made other findings.

3 The medical cause of death was

1a Suspension

1b

1c

II

CIRCUMSTANCES OF THE DEATH

4 On 13 September 2023, the Deceased had been assigned intermittent observations - four per hour - on Ellis Ward in Tolworth Hospital (a secure acute ward in a mental health

institution operated by South West London and St George's Mental Health NHS Trust - 'the Trust').

As a result of human error within an inadequate system, no member of staff was allocated to carry out intermittent observations between 1445 and 1805 hours on 13 September 2023, during which time the Deceased hanged himself. Because the member of staff allocated to intermittent observations was also expected to carry out general observations, it follows that there were no observations (save for the four patients on 1:1 observations) during that time.

Intermittent and general observations were and are generally carried out during the day by Healthcare Assistants (HCAs). The inquest heard evidence from a number of HCAs during the inquest and it was clear that observations were and are not carried out properly.

The Deceased's death occurred during a period of non-observation caused by human error and a faulty system of allocation which has now been changed. That in itself is not the current cause for concern.

CORONER'S CONCERNS

However, 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. -

The Trust's policy - in common with that of other Trusts - is that all observations should include an attempt, at least, at engagement. The written logs of observations suggest that, most of the time, no attempt is made at engagement during observations, in September 2023
5 or now. Intermittent observations may be recorded as, for example, 'Corridor - pacing' because the HCA has seen the patient but not attempted to engage with the patient. General observations, once per hour, appear to be no more than a headcount to make sure all patients are present on the ward (then and now).

This impression, gleaned from the documentation, appeared to be confirmed by the oral evidence of HCAs at the inquest.

It appears that the general and intermittent observations on Ellis Ward are not being carried out in accordance with the Trust's policy. If this was and remains the culture on Ellis Ward, it may also be the culture on other wards operated by the Trust (since some staff work on more than one Trust ward).

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you, as Chief Executive of the Trust, have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 3 June 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.

COPIES and PUBLICATION

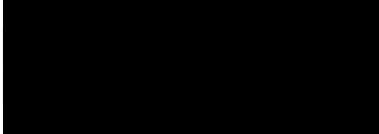
I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, [REDACTED] (the wife of the Deceased) and [REDACTED] (the niece of the Deceased on behalf of his family).

8 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.

7 April 2026

9 Signature

A large black rectangular redaction box covering the signature of the coroner.

Richard Furniss, HM Assistant Coroner for West London