MISS N PERSAUD
HIS MAJESTY'S AREA CORONER
EAST LONDON
East London Coroners, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • **Medica Reporting Services Ltd, Sixth Floor, One Priory Square, Hastings, East Sussex TN34 1EA**
1	**CORONER** I am Nadia Persaud, Area Coroner for the coroner area of East London
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 the 30 May 2022, I commenced an investigation into the death of Akash Dinesh Bhudia, age 28 years. The investigation concluded at the end of the inquest on 16 May 2023. The conclusion was that Mr Bhudia died as a result of natural causes. The inquest however heard evidence in relation to non-causal concerns in relation to the reporting of chest radiographs.
4	**CIRCUMSTANCES OF THE DEATH** Akash Bhudia suffered from a persistent cough from December 2021. On the 17 January 2022 he attended A&E where he underwent blood tests, chest Xray and medical reviews. The impression at this time was that he was suffering from community acquired pneumonia. He

	received a dose of intravenous antibiotics and intravenous fluids and was discharged from hospital with a course of oral antibiotics. Akash attended for a follow-up chest Xray on the 28 February 2022. This Xray showed progression in his left lung consolidation and showed a new consolidation in his right lung. The inquest heard that the primary diagnosis based on this Xray should have been tuberculosis. On the 4 March 2022, an emergency ambulance was called when Akash was found to be coughing and vomiting blood. Paramedics attended and provided emergency assistance. They could not however resuscitate Akash and his life was pronounced extinct by a paramedic. A post-mortem examination revealed a pulmonary abscess which was most likely to have been caused by tuberculosis. There is no evidence that any acts or omissions in the care provided to him, contributed to his death. The chest radiograph was not sent for analysis until 8 March 2022. The lack of an alert did not therefore contribute to Akash's death.
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 could 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 Xray on the 28 February 2022, which was carried out following treatment for pneumonia, showed an obvious progression in lung consolidation and was highly suggestive of tuberculosis (a new clinical diagnosis). Akash was not an in-patient in hospital at the time of the follow-up Xray. He had been discharged and was therefore not under the active management of a clinical team. The inquest heard that such significant, unexpected, and important changes should have been highlighted to the referring clinician. This was not done. There does not appear to be a process in place for an alert to be added to the normal communication method to ensure that such significant, unexpected, and important findings are acted upon in a timely manner. The inquest also heard that the incidence of TB is rising in certain areas of the UK and that it is important that radiologists recognise TB changes and that these are duly highlighted to the referrer.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 **14 July 2023.** 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 Interested Persons to the Inquest. I have also sent it to the local Director of Public Health, to the CQC and to the Royal College of Radiologists who may find it useful or of interest. I 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.

	I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**18 May 2023**