MR G IRVINE
SENIOR CORONER
EAST LONDON
East London Coroner's Court, 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:** 1. [redacted], **Chief Executive Officer, Barts Health NHS Foundation Trust** [redacted] 2. **Rt Hon Steve Barclay MP, Secretary of State for Health & Social Care** [redacted]
1	**CORONER** I am Graeme Irvine, senior 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 19th December 2022 this Court commenced an investigation into the death of Sultana Razia Choudhury aged 60 years. The investigation concluded at the end of the inquest on 24th August 2023. The court returned a short form conclusion of accident contributed to by neglect. Mrs Choudhury's medical cause of death was determined as; 1.a. Multi-organ Failure 1.b. Hypovolaemia 1.c. Renal Haemorrhage secondary to Renal Biopsy (7th December 2022)

4	**CIRCUMSTANCES OF THE DEATH** Sultana Choudhury was diagnosed with Diabetes and chronic kidney disease, she agreed to take part in a research project related to these conditions. On 7th December 2022 she consented to undergo a renal biopsy to harvest sample material in furtherance of the research programme. The procedure was completed after two attempts to take tissue. A week later Mrs Choudhury was admitted into hospital with abdominal pain, haematuria, rapidly worsening acute kidney injury and a positive for gram negative rods in blood cultures. Following diagnostic testing and imaging, Mrs Choudhury was admitted for treatment of a queried diagnosis of pyelonephritis and was administered enoxaparin for VTE risk. Mrs Choudhury was not adequately monitored whilst an inpatient. She died following a cardiac arrest in hospital on 17th December 2022. The cardiac arrest was caused by hypovolaemia which, in turn was caused by a undiagnosed renal haemorrhage the result of the renal biopsy 7 days earlier. The haemorrhage was exacerbated by contraindicated VTE prophylaxis.
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. – 1. The trust's failure to diagnose an obvious ongoing renal haemorrhage in a patient with; a recent history of renal biopsy, worsening clinical observations in keeping with hypovolaemia and a plummeting haemoglobin count. 2. The clinical decision to administer VTE prophylaxis in the form of low molecular weight heparin on admission to a patient with a patent bleed, evidenced by haematuria. 3. The failure to adequately monitor Mrs Choudhury during her 3-day admission that allowed her to deteriorate into a preventable peri-arrest state.
6	**ACTION SHOULD BE TAKEN** 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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **2nd November 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 following Interested Persons the family of Mrs Choudhury I have also sent it to the local Director of Public Health 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	**[DATE] 07/09/2023 [SIGNED BY CORONER]**