



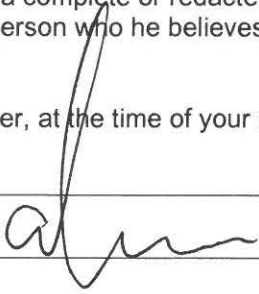
**MR G IRVINE  
SENIOR CORONER  
EAST LONDON**

**East London Coroner's Court, Queens Road Walthamstow, E17 8QP**  
[REDACTED]

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**  
[REDACTED]

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <ol style="list-style-type: none"><li>1. [REDACTED], Chief Executive Officer, Barts Health NHS Foundation Trust</li><li>2. Rt Hon Steve Barclay MP, Secretary of State for Health &amp; Social Care [REDACTED]</li></ol>
1	<p><b>CORONER</b></p> <p>I am Graeme Irvine, senior coroner, for the coroner area of East London</p>
2	<p><b>CORONER'S LEGAL POWERS</b></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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 19<sup>th</sup> 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 24<sup>th</sup> August 2023. The court returned a short form conclusion of accident contributed to by neglect.</p> <p>Mrs Choudhury's medical cause of death was determined as;</p> <ol style="list-style-type: none"><li>1.a. Multi-organ Failure</li><li>1.b. Hypovolaemia</li><li>1.c. Renal Haemorrhage secondary to Renal Biopsy (7th December 2022)</li></ol>

4	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>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.</p> <p>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.</p> <p>Following diagnostic testing and imaging, Mrs Choudhury was admitted for treatment of a queried diagnosis of pyelonephritis and was administered enoxaparin for VTE risk.</p> <p>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.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></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 <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"> <li>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.</li> <li>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.</li> <li>3. The failure to adequately monitor Mrs Choudhury during her 3-day admission that allowed her to deteriorate into a preventable peri-arrest state.</li> </ol>
6	<p><b>ACTION SHOULD BE TAKEN</b></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><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by <b>2<sup>nd</sup> November 2023</b>. I, the coroner, may extend the period.</p> <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.</p>
8	<p><b>COPIES and PUBLICATION</b></p> <p>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.</p>

	<p>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.</p> <p>I may also send a copy of your response to any other person who I 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><b>[DATE] 07/09/2023 [SIGNED BY CORONER]</b> </p>