North East Kent Coroners' Service
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Date: 17 June 2025
Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Cheif Executive, East Kent Hospitals NHS Trust

1. CORONER

I am Ms. Catherine Wood Assistant Coroner for North East Kent

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 6 November 2023 I commenced an investigation into the death of Upali METHTHANANDA. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Narrative
"He died as a result of bleeding from a severed blood vessel, a rare but recognised complication of thoracentesis. The hemorrhage occurred following the insertion of a chest drain to drain fluid from a left sided pleural effusion which arose as a complication of coronary artery bypass surgery for his underlying ischaemic heart disease."

1a Multi-Organ Failure

1b Hypovolemic Shock

1c Bleeding following thoracentesis (20 October 2023) for a pleural effusion following cardiothoraic surgery (3 October 2023)

1d

II Chronic Lymphocytic Lymphoma, Cerebrovascular Accident (Stroke) in the Past

4. CIRCUMSTANCES OF THE DEATH

Upali Meththananada was a 76 year old physiotherapist who despite his age was still working and active. He had a medical history of hypertension, ischaemic heart disease, chronic lymphocytic leukemia and previous stroke when he began to suffer from chest pain in early 2023. Coronary angiography revealed severe triple vessel disease and he was referred for coronary artery bypass surgery at St. Batholomew's hospital. He underwent surgery at St. Batholomew's on 3 October 2023 and his aorta was found to be heavily calcified so a decision was made to conduct the procedure without cardiopulmonary bypass. The procedure itself was complicated by bleeding and he required a number of blood products during surgery. He recovered following surgery but had a residual pleural effusion following removal of his chest drains but he was fit for discharge home when he left hospital on 10 October 2023.

He presented by ambulance to the Queen Elizabeth the Queen Mother hospital with chest pain and shortness of breath on 17 October 2023 and was admitted to the Coronary Care unit. Imaging revealed a large left sided pleural effusion which was creating a midline shift and following discussions with his earlier treating cardiologist, treating cardiothoracic surgeon and the cardiologist at Queen Elizabeth the Queen Mother hospital a decision was made to perform a chest drain locally.

The chest drain was inserted on the afternoon of 20 October 2023 at around 14.30 -15.00 and 700mls of blood stained fluid drained before the drain was removed. He was initially stable but following the insertion he collapsed with signs of hypovoleamia at 15.45 . An emergency call was initiated and help summonsed and attempts were made to correct his hypovolemia using blood products and drugs and discussions held with the team at St. Batholomew's about transferring him. He remained unstable and at around 18.15 suffered from a cardiorespiratory arrest and despite continued attempts at resuscitation including a thoracotomy to stem any bleeding he died at 19.40.

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 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. -

(1) I was concerned about the documentation as the inquest process had been hampered by the poor documentation and whilst I accepted that clinicians may have been providing care and not always documenting the care provided during this time the importance of documentation cannot be understated. However it was not just in the emergency setting where the clinical notes were lacking the clinical notes did not record key events and observations taken even in the period prior to his collapse. Clinical observations were not documented, meaning that trends were not available to treating clinicians and they would not have a full picture upon which to base any clinical decisions. Discussions between clinicians at other organisations were also not documented and forms used by the hospital for procedures were not used as required even by experienced clinicians. Whilst I heard some improvements had been made by the witness who presented the Trust's action plan I remained concerned that the failure to document procedures and observations as well as advice given from third parties could lead to clinicians who take over care for a patient not having a full picture and leading to risks to patients in the future.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you the Chief Executive at East Kent Hospitals NHS Trust 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 13 August 2025. 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 Mr. Meththanada's family and Barts NHS Trust.

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.

17 June 2025

Signature 

Catherine Wood Area Coroner for North East Kent