



**MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON**

East London Coroner's Court, Queens Road Walthamstow, E17 8QP

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [REDACTED] CEO Barking, Havering and Redbridge University Hospitals NHS Trust [REDACTED] [REDACTED]
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 8 November 2024 I commenced an investigation into the death of Matthew Goldsmith (44 years old at the time of his death). The investigation concluded at the end of the inquest on the 7 October 2025. The conclusion of the inquest was a narrative conclusion: <i>Mr Goldsmith died as a result of an occluded superior mesenteric artery. The stenosed artery was apparent, but missed, on the reporting of a CT scan in April 2024. Identification of this pathology in April 2024 would have prevented his death.</i>
4	CIRCUMSTANCES OF THE DEATH Matthew Goldsmith had a past medical history of epilepsy and a smoking history from the age of 16. From March 2023, he suffered from intermittent abdominal pain, loose stools and significant weight loss. In March 2024 he was referred to the colorectal team by his general practitioner. Investigations were undertaken, including a CT scan of the chest, abdomen and pelvis. The CT scan was reported as showing no significant abnormality. Malignancy was excluded. The CT scan did not report a severe stenosis of the superior mesenteric artery which could be seen on the lower section of the chest CT scan. These findings were relevant to his clinical presentation. Had this finding been identified and reported, this would have indicated referral to the vascular surgical team. Had such a referral been made, there was an opportunity of providing care to Mr. Goldsmith which would have prevented his death. On the 7 October 2024, Mr. Goldsmith presented to the emergency department with increasing abdominal pain, continuing loose stool and substantial weight loss. Investigations were requested, including a CT scan of the abdomen. The CT scan of the abdomen reported occlusion of the infrarenal aorta and thinning of the small bowel wall, which could reflect chronic ischaemia. The reporting radiologist did not identify a complete occlusion of the superior mesenteric artery. If this finding had been identified, there would have been an opportunity to refer Mr. Goldsmith to the vascular surgical team. The evidence does not reveal that referral to the vascular surgical team at this time would have prevented his death. A colonoscopy revealed a chronic fibrotic ulcer, which was believed by the treating team (physician and gastroenterologist) to have caused Mr. Goldsmith's symptoms. Mr. Goldsmith was discharged from hospital on 16 October 2024. Sadly, on the 28 October 2024, Mr. Goldsmith returned to the emergency department severely unwell, with severe abdominal pain. A working diagnosis of shock due to an acute on chronic bowel ischaemia, due to aortic occlusion was made. Despite all efforts at this time, Mr. Goldsmith did not recover. He passed away at Queen's Hospital on the 29 October 2024. He died as a result of an occluded superior mesenteric artery causing bowel ischaemia and bowel perforation
5	<u>CORONER'S CONCERNS</u> 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: Abnormal findings in the abdominal vascular system were apparent on 3 CT scans from January 2020 to October 2024 but not reported by the reviewing radiologists. In January 2020 a CT trauma scan was carried out following a road traffic collision. This scan showed an occluded right common iliac artery and origin of inferior mesenteric artery. Whilst these findings were not relevant to the clinical condition at the time, they should have been reported. In April 2024 the CT scan of the chest showed occlusion of the infrarenal aorta, bilateral common iliac artery and right external iliac artery. There was severe stenosis of the superior mesenteric artery in its mid segment. The latter finding was of direct clinical interest. None of these findings were reported. On 10 October 2024 an abdominal CT scan showed occlusion of the superior mesenteric artery mid segment. This was directly relevant to the clinical condition and it was not reported. The Royal College of Radiologists Guidance requires peer review of 5-10% of reported radiology cases as part of a Trust's quality assurance process. At the date of the inquest, Barking Havering & Redbridge NHS Trust does not have such a peer review system in place. In light of the number of missed radiological findings in this case, by 3 separate radiologists, it is of concern that the peer review process is not taking place at the trust.
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 4 December 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 family of Mr Goldsmith, to the Care Quality Commission and 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	9 October 2025 