MR G IRVINE
SENIOR CORONER
EAST LONDON CORONERS COURT
124 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]
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 17th September 2024, this court commenced an investigation into the death of Mohammad Ali Asghar aged 82 years. The investigation concluded at the end of the inquest on 14/05/2025. The court returned a narrative conclusion. *"Mohammad Ali Asghar died in hospital on 14th September 2024. Dr Asghar was admitted to hospital with shortness of breath and fluid overload on 8th September 2024. During treatment, Dr Asghar suffered a cardiac arrest caused by, haemorrhagic pericarditis, heart failure and an iatrogenic injury to his bladder caused during necessary catheterisation."* Mr Asghar's medical cause of death was determined as;

	1a Cardiac arrest 1b Haemorrhagic Pericarditis, Iatrogenic bladder haemorrhage 1c Decompensated heart failure II Hypertension, Cirrhotic Liver (Cryptogenic), Old Myocardial Infarction
	CIRCUMSTANCES OF THE DEATH Mr Asghar was admitted to hospital on 8/9/24 with worsening shortness of breath on exertion. Following tests it was identified that Mr Asghar was suffering from decompensated heart failure with hypervolaemic hyponatraemia (low sodium caused by fluid overload), deranged liver function and constipation. Mr Asghar treatment included intravenous diuresis to offload fluid and he was commenced on a fluid restriction, daily bloods and weights were requested. A catheter was inserted on 13/9/24 to help monitor fluid input and output monitoring. Following catheterisation there was some haematuria with clots (blood in the urine) and the plan was to replace the catheter. Following removal of the catheter the patient went to the toilet to pass urine and collapsed. Mr Asghar went into cardiac arrest and CPR was unsuccessful.
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. A failure in governance at the Trust meant that this case was not identified as an incident worthy of investigation through the Patient Safety Framework. This omission gives rise to a concern that future deaths may follow due to an inability on the part of the trust to identify, reflect upon, and remediate sub-optimal practice. In this case the trust's Datix incident reporting system, morbidity and mortality meeting process and PSIRF procedure were inadequate. 2. Despite concerns being raised by a medical examiner, a coroner's court finding that an iatrogenic injury was contributory to death, and an express direction from this court for the case to be reviewed, no patient safety framework investigation has occurred. 3. Correspondence received from the Trust sent three months after the inquest that seeks to explain why a PSRF investigation was not undertaken in this case betrays the fact that senior governance staff at the Trust still do not understand NHS England guidance on what should trigger a patient safety investigation.
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 **23rd November 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 the family of Mr Asghar, the Care Quality Commission, NHS England 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	**[DATE] 29/09/2025 [SIGNED BY CORONER]**