REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Interim Group Chief Executive Officer, St George's University Hospitals, NHS Foundation Trust, Blackshaw Road, London. SW17 0QT
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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.
3	**INVESTIGATION and INQUEST** On 3rd November 2025 evidence was heard touching the death of Mr Barry Clive Loxston. He had died at St George's Hospital on 30th July 2023 aged 67 years. **Medical Cause of Death** Ia Electrolyte and metabolic abnormality with acute n chronic diarrhoea Ib Delayed renal transplant graft function (transplant performed on 8/7/2023), Clostridium Difficile infection (treated) and chronic pancreatic insufficiency II Hypertensive heart disease. **How, when and where the deceased came by her death.** Mr Loxston suffered with dialysis dependent renal failure secondary to long term use of indomethacin for ankylosing spondylitis. He was admitted for renal transplant surgery on 8/7/2023 to St George's Hospital. This went ahead despite failures to recognise that he was unfit for surgery due to malabsorption causing low albumin from chronic diarrhoea by his nephrology team in St Helier Hospital and the transplant team at St George's. These were serious failures that contributed to Mr Loxston's death. The surgery was initially successful, however post operatively he developed complications due to low albumin contributing to circulatory failure, electrolyte imbalance, and delayed graft function. From 29/7/2023 his potassium was dangerously low. This was not treated until 30/7/2023 in part due to workload acuity. On 30/7/2023 he arrested and was initially resuscitated but died shortly after.

Conclusion of the coroner as to the death:

Mr Loxston died as a result of serious failures to recognise that he was unfit for renal transplant surgery

4 **Evidence Relevant to the Matters of Concern:**

Extensive evidence was taken from the family, nurses and doctors and the pathologist.

Mr Loxston had been placed on the transplant waiting list by his nephrologist in his local hospital St Hellier. He had not been removed from that list despite later suffering chronic diarrhoea, requiring dietician advice and supplements to maintain his weight and a falling albumin in last months of his life.

Mr Loxston had fallen and broken his clavicle as he arrived at the hospital in the early hours of the morning for the transplant surgery. This did not impact upon his fitness for anaesthetic however it significantly affected his ability to move in bed and selfcare postoperatively and caused him significant pain. There were multiple instances reported by the family when the nursing staff on the renal ward (Champney's ward) did not follow proper manual handling techniques and pulled on the side of his broken clavicle causing him significant pain.

He suffered severe diarrhoea and on more than one occasion he was left lying in his own excrement after a failure to bring a commode. On one occasion he was left lying in this way for almost 5 hours. Again, the evidence was that this occurred on the renal ward.

There was no doubt that the nursing matters outlined above had a significant detrimental effect on his mental wellbeing and he was described by the nephrologist who cared for him at St George's in the postoperative period as being low in mood and to simply have had enough. Whilst it could not be found that these matters directly caused or contributed to his death, I was satisfied that they possibly did so by affecting his overall wellbeing following serious surgery and its complications.

Also whilst on Champney's ward, there were errors in administration of his medication, and multiple times when the taking of his medication was unsupervised such that medication was found on his bed or on the floor by the family. The family raised these matters with the nursing staff when they occurred with variable response from the nursing staff.

The error in medication administration was for the drug given to prevent rejection of his new kidney. This was dealt with robustly by the ward staff. However, evidence was taken that medication is often administered but left with patients to take in their own time and that this then self-administration is often unsupervised. This was not investigated by the ward and so it was not known what medication was missed by Mr Loxston.

	It was only a matter of speculation as to whether drug administration failures and errors contributed to the death due to lack of evidence. However, I note that there was delayed graft function clinically and signs of resolving rejection found at postmortem examination of the donated kidney. As part of the presurgical workup a panel of blood tests were taken that included albumin level. This was on admission testing to be exceptionally low at 14g/l, normal range 35-50g/l. No clinician appears to have noted nor raised this abnormal result pre-operatively. This low albumin directly caused and contributed to the post operative complications that caused Mr Loxston's death. In evidence all witnesses questioned agreed that he should have not had surgery with such a low level of albumin, due to post operative complication risk, especially as the cause of it was unexplained and in fact reflected chronic active unresolved illness. His death was therefore both preventable and predictable. Just 2 days prior to his admission, his albumin had been found in dietician clinic at St Hellier to be 16g/l. this had not been followed up prior to admission for transplant surgery nor did the local nephrology team appear to have reviewed Mr Loxston's suitability to be on the transplant waiting list. The evidence was unanimous from witnesses that given his chronic diarrhoea and malabsorption he should not have been on that list. I understand that the transplant team at the time did not have access to clinic letters or results held at St Hellier for Mr Loxston. Nor did they contact his local nephrologist. I understand that access to local records has now improved and it has been suggested that every time such a patient is reviewed by his local nephrologist their suitability as to whether or not they should be on the transplant list should be reviewed and recorded.
5	**Matters of Concern** 1. That poor patient handling and allowing patients to lie for hours in their own excrement is detrimental to patient wellbeing and may contribute to deaths. 2. That leaving medication with patients for them to take in their own time rather than supervise the taking of medication by the patient causes drug maladministration issues that may cause or contribute to deaths of patents. 3. That lack of investigation of the matter outlined in 2 increases the risk to patients of the concern outlined in 2. 4. That all relevant blood tests, including albumin level since low albumin may be associated with significant post operative complication risk, are not reviewed prior to surgery and considered as part of the risk/benefit analysis of surgery and the consenting process.

	5. That there is no system mandating suitability to remain on the transplant list by the local nephrologist at each nephrology review. 6. That there is no system recommending direct contact with the local on call nephrology team by the transplant team to check whether there are clinically relevant matters in relation to the patient and their suitability for transplant that the local team are aware of and the transplant team are not, such as active other chronic illness or abnormal test results.
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. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: [redacted] [redacted] Consultant Nephrologist, Epsom and St Helier University Hospital NHS Trust (by email to the hospital legal team) [redacted] Consultant Nephrologist, St George's University Hospital (by email to hospital legal team) [redacted] Consultant Nephrologist, St Geroge's University Hospital (by email ibid) [redacted] Consultant Transplant Surgeon,

	St George's University Hospital (by email ibid) [redacted] Ward Manager Champney's Ward, St George's Hospital university Trust (by email ibid) 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.
9	**12th November 2025** **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR** [redacted]