MISS N PERSAUD
HIS MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 13422724

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Rt Hon Therese Coffey, Secretary of State for Health & Social Care [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 23 June 2021 I commenced an investigation into the death of Oli Akram Hoque (aged 26 years old). The investigation concluded at the end of the inquest on the 7 October 2022. The conclusion of the inquest was a narrative conclusion: *Oli Hoque died as a result of a very rare complication of a COVID-19 vaccination.*
4	**CIRCUMSTANCES OF THE DEATH** Oli Hoque received his first dose of the Astra Zeneca Covid-19 vaccination on the 19 March 2021. On or around the 1 April 2021 he began to suffer from headaches. These became progressively worse and on the evening of the 4 April 2021 he attended A&E at King Georges Hospital. Oli did not present with any symptoms at this time which would have required assessment in the emergency department. In the late evening of the 5

	April 2021, Oli was suffering from a severe headache. His sister took him to the Royal London Hospital. A general practitioner assessed Oli and found no signs of raised intracranial pressure. The general practitioner did not consider that Oli required further assessment in the emergency department. At around 11am on the 6 April 2021 Oli's condition declined significantly and an ambulance was called. Oli was suffering from seizures at this time and was taken urgently to Queen's Hospital. In hospital, radiological investigations revealed a cerebral venous sinus thrombosis. Oli received care from a multi-disciplinary team and the agreed impression was that the cerebral venous sinus thrombosis was vaccine induced. Sadly, despite all attempts to provide treatment to Oli, he passed away at Queen's Hospital on the 15 April 2021. On the 7 April 2021 the MHRA issued new advice to healthcare professionals on a possible link between the Astra Zeneca COVID-19 vaccine and specific types of blood clot.
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: The Inquest heard evidence from a senior medical assessor from the Medicines and Healthcare Regulatory Agency (MHRA). The Inquest heard that from the 25th February 2022 the MHRA investigated the potential signal of immune thrombocytopenia. This identified three cases of cerebral venous sinus thrombosis which could possibly be associated with the Astra Zeneca Covid 19 vaccine. The MHRA could not fully consider these cases as they did not receive all of the necessary clinical information. The Inquest heard that the MHRA do not have the power to compel relevant clinical information, to assist them with safety investigations. In light of the clear public interest in ensuring that the MHRA are able to carry out robust safety investigations, it is a matter of concern that the MHRA are unable to compel the timely production of relevant clinical data.
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 **8th December 2022**. 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 to the Inquest, family of Mr Hoque 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	**13/10/2022**