MR G IRVINE
SENIOR CORONER
EAST LONDON
East London Coroner's Court, Adult Learning College, 127 Ripple Road, Barking, IG11 7PB
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 14947560

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** • [redacted], Chief Executive, The Barking Havering and Redbridge University NHS Trust, Queen's Hospital, Rom Valley Way, Romford, Essex RM7 0AG Email: [redacted] • [redacted], Chief Executive, British Association of Urological Surgeons Ltd, Royal College of Surgeons, 38 - 43 Lincoln's Inn Fields, London WC2A 3PE Email: [redacted] • The Secretary of State for Health and Social Care, 39 Victoria St, Westminster, London SW1H 0EU Email: [redacted]
1	**CORONER** I am Graeme Irvine, acting 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 20th August 2021 I commenced an investigation into the death of Mr Graham Edgar White aged 72 years. The investigation concluded at the end of the inquest on 13th July 2022. I made a determination of a narrative conclusion incorporating a finding of neglect; *Mr Graham Edgar White died in hospital on 18th August 2021 following surgery to remove a antegrade ureteric stent of his right ureter.* *The stent was inserted in November 2019 and should have been removed after three months. The stent deteriorated causing a urinary tract infection and a right peri-nephric abscess.* *On multiple occasions in a 20-month period the deterioration of the stent was observed but no action was taken to remove it.* *Mr White's death was contributed to by neglect.* *Mr White's medical cause of death was determined as;* *1a Sepsis* *1b Right Perinephric Abscess* *1c Urinary tract infection in relation to longstanding ureteric stent inserted for ureteric stone* *II Ischaemic Heart Disease*
4	**CIRCUMSTANCES OF THE DEATH** Mr Graham Edgar White was treated for a ureteric stone in November 2019 by the insertion of an antegrade ureteric stent. The stent was intended to be a temporary measure that should not have remained in place longer than three months. Over the next 20 months, the deterioration of the stent was observed through imaging on at least four occasions, despite this, it was not until Mr White suffered a urinary tract infection and a right perinephric abscess that the stent was removed during difficult surgery in July 2021. Mr White developed Sepsis and died on 18th August 2021.
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. Trust did not have in place a registry of those fitted with stents that would facilitate monitoring and recall of patients. 2. At the time of the inquest the Trust are unable to assess whether they have patients with stents inserted prior to May 22 who are at risk of a similar deterioration. 3. The Trust did not successfully identify and escalate this death through its governance procedures as a serious incident for investigation until the issue was raised by the Coroner.
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 **Tuesday 13th September 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 the family of Mr White and the CQC. I have also sent it 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] 18th July 2022** **[SIGNED BY CORONER]**