



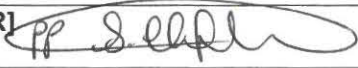
MR G IRVINE  
SENIOR CORONER  
EAST LONDON

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

**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

	<p><b>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</b></p> <p><b>THIS REPORT IS BEING SENT TO:</b></p> <p>1. [REDACTED], Chief Executive Officer, Barking, Havering &amp; Redbridge, University Trust [REDACTED]</p>
1	<p><b>CORONER</b></p> <p>I am Graeme Irvine, senior coroner, for the coroner area of East London</p>
2	<p><b>CORONER'S LEGAL POWERS</b></p> <p>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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a></p>
3	<p><b>INVESTIGATION and INQUEST</b></p> <p>On 19<sup>th</sup> April 2023 I commenced an investigation into the death of Marion May Luckraft aged 84. The investigation concluded at the end of the inquest on 11<sup>th</sup> September 2023. The conclusion of the inquest was a short-form conclusion of natural causes.</p> <p>The medical cause of death was found to be;</p> <p>1a Shock due to biliary sepsis</p> <p>1b Retroperitoneal duodenal perforation following endoscopic retrograde cholangiopancreatography (ERCP) and placement of pancreatic stent.</p> <p>1c Biliary obstruction due to upper gastrointestinal malignancy</p>
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	<p><b>CIRCUMSTANCES OF THE DEATH</b></p> <p>Mrs Luckraft was admitted to hospital on 31/3/23 with jaundice.</p> <p>Diagnostic tests suggested an obstructed biliary system, an ultrasound scan showed a dilated common bile duct (CBD).</p> <p>Further imaging occurred on 2/4, a CT abdomen with findings suggestive of CBD stricture and possible malignancy. A MRCP (Magnetic Resonance Cholangiopancreatography) provided a corroborative result on 4/4.</p> <p>On 11/4 an ERCP (Endoscopic Retrograde Cholangiopancreatography) was undertaken and an unsuccessful attempt to insert a stent into the CBD was undertaken. A stent was inserted in the pancreatic duct.</p> <p>A CT scan 13/4 on showed a duodenal perforation by displaced biliary stent with retroperitoneal gas/fluid.</p> <p>A number of factors; the patient's deterioration, an attempt at drainage through interventional radiology, and discussion regarding which hospital site should be utilised, led to delays in transferring the patient to another hospital for a laparotomy and washout which occurred on 16/4.</p> <p>The patient passed away on 17/4/23 on ITU.</p>
5	<p><b><u>CORONER'S CONCERNS</u></b></p> <p>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.</p> <p>The <b>MATTERS OF CONCERN</b> are as follows. –</p> <ol style="list-style-type: none"> <li>1. Cumulative delays in the execution of diagnostic processes and treatments of the patient probably increased the risk of Mrs Luckraft developing biliary sepsis.</li> <li>2. Following the duodenal perforation suffered by the patient there was a failure to promptly escalate her care to a high dependency unit despite her NEWS score of 8.</li> <li>3. The fragmentation of the patient's treatment across two sites of the Trust contributed to delays in her treatment.</li> <li>4. The absence of a clear and workable treatment pathway fro biliary sepsis contributed to delays.</li> </ol>
6	<p><b>ACTION SHOULD BE TAKEN</b></p> <p>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.</p>
7	<p><b>YOUR RESPONSE</b></p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely b 13<sup>th</sup> <b>November 2023</b>. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p><b>COPIES and PUBLICATION</b></p>

	<p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons the family of [REDACTED]. I have also sent it to the local Director of Public Health who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>[DATE] 29/09/2023 [SIGNED BY CORONER] </p>