MR G IRVINE
SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, 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, Barking, Havering & Redbridge, University 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 19th 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 11th September 2023. The conclusion of the inquest was a short-form conclusion of natural causes. The medical cause of death was found to be; 1a Shock due to biliary sepsis 1b Retroperitoneal duodenal perforation following endoscopic retrograde cholangiopancreatography (ERCP) and placement of pancreatic stent. 1c Biliary obstruction due to upper gastrointestinal malignancy
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	CIRCUMSTANCES OF THE DEATH Mrs Luckraft was admitted to hospital on 31/3/23 with jaundice. Diagnostic tests suggested an obstructed biliary system, an ultrasound scan showed a dilated common bile duct (CBD). 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. 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. A CT scan 13/4 on showed a duodenal perforation by displaced biliary stent with retroperitoneal gas/fluid. 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. The patient passed away on 17/4/23 on ITU.
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. Cumulative delays in the execution of diagnostic processes and treatments of the patient probably increased the risk of Mrs Luckraft developing biliary sepsis. 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. 3. The fragmentation of the patient's treatment across two sites of the Trust contributed to delays in her treatment. 4. The absence of a clear and workable treatment pathway fro biliary sepsis contributed to delays.
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 b **13th November 2023**. 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 [redacted]. 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] 29/09/2023 [SIGNED BY CORONER]**