REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive of East Suffolk and North Essex NHS Foundation Trust**
1	**CORONER** I am Sonia Hayes, Area Coroner, for the coroner area of Essex
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 3 May 2024 I commenced an investigation into the death of DAVID HEFFER, AGE 84. The investigation concluded at the end of the inquest on 23 April 2025. The conclusion of the inquest was I(a) Septicaemia (b) Acute peritonitis (c) Duodenal and Omental Perforation Post Endoscopic Retrograde Cholangio Pancreatography (d) II Ischaemic Heart Disease, Obstructive Jaundice Mr Heffer died from a rare but recognised complication of a necessary medical procedure and the stent added to the risk of this complication.
4	**CIRCUMSTANCES OF THE DEATH** David Heffer died on 13 April 2024 of Septicaemia due to Acute Peritonitis secondary to Duodenal and Omental Perforation Post Endoscopic Retrograde Cholangio Pancreatography (ERCP) on 8 April 2024 for Obstructive Jaundice in a background of Ischaemic Heart Disease. Mr Heffer was discharged the

	same day as the ERCP and readmitted on 9 April 2024 in severe pain and diagnosed with biliary sepsis and perforation. Mr Heffer received treatment for sepsis but was not suitable for surgical intervention due to his underlying bladder cancer and probable cholangiocarcinoma.
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 will 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) The treating doctor was not informed when Mr Heffer was readmitted with a complication of the ERCP procedure, and his advice was not sought about potential causes of the complication. The treating doctor only found out about the readmission on contact from coroner's office. (2) The medical records did not contain all of the pertinent and relevant information and some were illegible causing difficulty in interpretation.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 30 July 2025. 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: • Family I have also sent it to Care Quality Commission who may find it useful or of interest.

	The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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	 **4 JUNE 2025** **HM Area Coroner for Essex Sonia Hayes**