East London Coroners Court
124 Queens Road
Walthamstow
E17 8QP

Newham University Hospital
Glen Road
London
E13 8SL

Dear Mr Irvine,

Re: Regulation 28 Report to Prevent Future Deaths – Mr Tony Buengo Jackson [redacted]

Thank you for your Regulation 28 Report dated 23 September 2025 following the inquest into the death of Mr Tony Buengo Jackson. On behalf of Barts Health NHS Trust, I wish to express our sincere condolences to Mr Jackson's family and to acknowledge the seriousness of the concerns you have raised.

A detailed internal review has been undertaken to ensure the circumstances identified during the inquest are fully understood and that corrective actions are being implemented.

Below I set out our response to each matter of concern and the steps we are taking to prevent similar events in future.

1. Failure to recognise iatrogenic injury and missed opportunity on re-admission

You expressed concern that the iatrogenic bowel injury sustained during the PEG insertion on 19 November 2024 was not recognised until 3 December 2024, despite a CT scan and surgical review on 24 November.

Our review confirmed that the consultant surgeon's interpretation of the CT scan at that time represented a reasonable differential diagnosis given the available evidence. However, the rationale for this interpretation was not fully documented, limiting retrospective understanding of the decision.

Actions taken

- The case has been reviewed through the Surgical Division's Morbidity and Mortality (M&M) process and learning shared.

Status: Implemented October 2025; monitored via monthly M&M.

2 & 3. Documentation of best-interest decision-making and availability of clinical records

You highlighted concerns regarding the completeness of documentation for best-interest discussions and noted that not all records from the 24 November admission were available.
The Trust acknowledges that discussions with Mr Jackson's family took place over several encounters and were clinically appropriate, but the rationale and outcomes of these discussions were not always documented in a clear and consistent format. We also acknowledge that retrieval of some legacy paper documentation for disclosure was incomplete.

Actions taken:

- The Trust has reinforced the requirement that all best-interest discussions are documented in the patient record, clearly recording:
    - who was present,
    - the clinical reasoning and evidence considered,
    - risks and benefits discussed,
    - and the agreed outcome.
        - This reflects Royal College of Physicians and BMA guidance that best-interests' decisions are iterative and revisited over time, rather than a one-off meeting, and ensures the decision-making process remains transparent and clinically grounded.
- Guidance has been re-issued to consultants and trainees regarding documentation standards for capacity assessments and best-interest decisions. This has been discussed in divisional Clinical Governance meetings and included in Resident Doctor teaching.
- E-consent has been rolled out in endoscopy in the last 12 months and includes a detailed section for consent form 4 and best interests discussions. Currently only a limited number of clinicians have access to this system.

Status: This will be discussed in the Gastroenterology Governance Meeting in December to standardise process and expand the number of users to the Concentric Platform to further reduce the use of paper documentation for consent form 4 with improved integration with the electronic patient record.

4. Governance and incident-reporting failure under the Patient Safety Incident Response Framework (PSIRF)

You highlighted that the case was not identified for investigation under PSIRF and that incident-reporting and governance processes were inadequate.

The Trust acknowledges that a Datix record was not submitted contemporaneously, which represents a missed opportunity for formal learning. An internal review has since strengthened how patient-safety incidents are identified, triaged, and escalated.

Actions taken

- A Trust-wide communication was issued in October 2025 reminding staff that all significant or unexpected complications, including recognised but serious procedural injuries, must be recorded on Datix for PSIRF consideration.

- All deaths that proceed to Coroner's inquest are now reviewed at the Patient Safety Event Response Meeting (PSERM) to ensure:

    - The event is captured on Datix,

- The circumstances are reviewed in a multidisciplinary forum, and

- An appropriate learning response (e.g learning response review, MDT case discussion, thematic review or QI feedback) is agreed and assigned.

- The Endoscopy Governance Meeting is being expanded to include the surgical directorate as a bi-monthly joint forum agenda (within the Gastroenterology Governance Forum) between Surgery and Gastroenterology, with governance and nursing representation, to support shared learning from endoscopy-related adverse events.

- Governance presence is now embedded within Surgical and Gastroenterology M&M meetings to ensure improved linkage between M&M learning, Datix reporting, and PSIRF oversight.

- The Trust is also strengthening the recording of Morbidity and Mortality (M&M) discussions across all divisions. Following a review of M&M processes at the December Quality and Safety Committee, divisions will be supported to embed improved documentation standards and the use of Microsoft Copilot to capture decisions, themes and actions. This will ensure that learning identified at M&M is consistently recorded, traceable, and easily retrievable for follow-up through PSERM and divisional governance structures.

Status: This will be discussed in the Gastroenterology Governance Meeting in December to standardise process

5. Summary and assurance

Barts Health NHS Trust recognises that Mr Jackson's death resulted from a rare but serious PEG-related complication, and that aspects of documentation and governance did not meet the standard we expect. We have taken decisive steps to strengthen clinical documentation within the electronic patient record , improve governance, and reinforce a culture of proactive incident reporting and shared learning.

Progress will be monitored through the Trust's Quality & Safety Committee. We believe these measures provide a robust response to the risks identified in your report and will meaningfully reduce the likelihood of similar events recurring.

Yours sincerely,

[redacted]

Chief Medical Officer