MR G IRVINE
SENIOR CORONER
EAST LONDON CORONERS COURT
124 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, Barts Health NHS Foundation Trust** [redacted] **2. [redacted]g, Secretary of State for Dept. Health & Social Care** [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 27th December 2024, this court commenced an investigation into the death of Tony Buengo Jackson aged 57. The investigation concluded at the end of the inquest on 22nd September 2025. The court returned a narrative conclusion. *"Tony Buengo Jackson (Known as Jackson) died in hospital on 13th December 2024. He died of peritonitis caused by intestinal content slipping into his abdomen from a bowel perforation caused by a*

	misplaced Percutaneous Endoscopic Gastronomy apparatus fitted in hospital on 19/11/24." Mr Tony-Buengo's medical cause of death was determined as; 1a Peritonitis 1b Perforation of Transverse Colon by Percutaneous Endoscopic Gastronomy (Peg) Tube 1c Multiple Sclerosis
	CIRCUMSTANCES OF THE DEATH Jackson Tony Buengo was 57, he lived in a nursing home due to progressive MS. In the final year of his life he sustained frequent chest infections attributable to aspiration. On 9/11/24 admitted to WXH with pneumonia. To mitigate the risk of further episodes of aspiration, a best interests decision was made to fit a Percutaneous Endoscopic Gastronomy ("PEG") to provide nutrition. On 19/11/24 a nurse endoscopist under supervision of consultant gastroenterologist, carried out the PEG insertion procedure, apparently without incident. An iatrogenic injury occurred that went undetected. the Peg tube was passed through the stomach and then straight through the transverse colon and out through the peg port in the skin. Jackson was discharged to his care home on 20/11/24. In the following week concerns were raised intermittently by Care home of abdominal distention - concerns are escalated to 111, community care response. On 24/11/24 taken hospital by ambulance, a CT scan showed bubbles of gas in Jackson's abdomen and was reported on by a consultant radiologist as being probably due to a bowel perforation. The report went on to recommend a surgical consultation for a potential resection of the bowel. The findings were interpreted by the attending consultant surgeon as being attributable to an air-leak caused by the Peg apparatus not pressing the stomach wall tightly to inside of abdominal wall. A surgeon retracted the peg to press against interior abdominal wall and Jackson was again discharged on 27/11/24. On 3/12/24 was admitted to the ED by ambulance with sepsis and a distended abdomen. Jackson was again referred to the surgical team and his peg was again withdrawn and re-fixed. A repeat CT scan confirmed that the PEG insertion had transfixed his colon. Mr Jackson was palliated and died on 13/12/24.
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. A fatal iatrogenic injury caused to Jackson on 19th November 2024 went undetected until 3rd December 2024, despite admission, CT scan and surgical consult on 24th November 2024. 2. Records of, best interest decisions, the PEG insertion and subsequent treatment

	were so poor as to impede the court's investigation. 3. The Trust could not provide notes of the 24th November admission. 4. A failure in governance at the Trust meant that this case was not identified as an incident worthy of investigation through the Patient Safety Framework. This omission gives rise to a concern that future deaths may follow due to an inability on the part of the trust to identify, reflect upon, and remediate sub-optimal practice In this case the trust's Datix incident reporting system, morbidity and mortality meeting process and PSIRF procedure were inadequate.
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 **18th November 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 the family of Mr Tony Buengo Jackson, the Care Quality Commission and 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] 23/09/2025 [SIGNED BY CORONER]**