NHS
Barking, Havering and Redbridge
University Hospitals
NHS Trust

Legal Services
Queen's Hospital
Rom Valley Way, Romford, RM7 0AG

[redacted]

Private and Confidential
Mr G Irvine
HM Area Coroner
Walthamstow Coroner's Court
Queens Road
London

Date: 5 May 2026

Dear Mr Irvine,

Re: Regulation 28 Report to Prevent Future Deaths: Sheila Creegan
Ref: 31805348

Thank you for your Regulation 28 Report dated 10 March 2026 concerning the death of Mrs Sheila Creegan, and for setting out your concerns in relation to the Trust's decision not to undertake a Patient Safety Incident Response Framework (PSIRF) investigation in this case, together with the issues identified regarding diagnosis, monitoring and investigation of Mrs Creegan's condition.

On behalf of Barking, Havering and Redbridge University Hospitals NHS Trust, I would like to acknowledge the seriousness of the concerns raised and to assure the Court that the Trust accepts the importance of ensuring that our systems for learning are robust, multidisciplinary, and capable of identifying opportunities to prevent future harm.

PSIRF is the Trust's core framework for proportionate, systems-based patient safety learning of clinical incidents however, it is not the only mechanism through which care is clinically reviewed, appraised, and learned from. The Trust wishes to assure HM Coroner that learning from deaths and from care that is subject to coronial scrutiny is not derived solely through our PSIRF processes.

The Trust recognises that there are circumstances where more explicit multidisciplinary clinical review is required, particularly in complex cases where deaths are subject to inquest, and where the Court has identified potential concerns regarding the care provided. As set out in a recent Trust internal governance paper on PSIRF and inquest preparedness, the Trust explains that PSIRF is not designed to prepare witness evidence or satisfy the questions of causation required in coronial or legal processes. The Trust has recognised that this may lead to cases that do not undergo a PSIRF Learning Response as learning has already been identified and improvement activity is already underway. The NHSE Patient Safety Incident Response Framework permits the Trust to not undertake a full PSIRF Learning Response in these cases, and to proceed with the learning and improvement that has been identified following a local investigation.

To have good governance process to support these decisions, HM Coroner will be aware that the Trust has now established a Coroner's Case Review Meeting (CCRM) as part of its formal coronial governance arrangements.

The CCRM provides a structured forum for a multidisciplinary clinical review of the care provided in cases proceeding to inquest or subject to heightened coronial scrutiny. This process is distinct from, but complementary to, PSIRF. It enables relevant senior clinicians and professional leads to come together to review the chronology, examine the care delivered, identify any gaps, and consider what learning or action is required. It also provides a mechanism through which the Trust's senior leadership, including the Chief Medical Officer, can ask direct questions of the care given, seek clarification from clinical teams, and appraise whether the care was reasonable, whether concerns remain, and whether further action or review is necessary. This strengthens oversight in a way that sits outside the boundaries of PSIRF's defined remit.

The Trust agrees that learning should not be constrained by whether a case meets a particular PSIRF learning response threshold. In these cases, a number of review methods have been, and continue to be, used to examine the care provided and identify learning. These include:

- a multidisciplinary team (MDT) review of the care pathway;
- mortality review processes;
- the complaints investigation and response process;
- review through the newly established CCRM, including a documented outcome form;
- witness statements and reflective accounts from the medical staff and wider MDT involved in the care.

These documents and reviews together provide a full picture of the care delivered, the decision-making at the time, and the areas where there is learning for the organisation. They also enable scrutiny from several different perspectives: clinical, professional, legal and where given, family experience. The Trust will continue to make these materials available to HM Coroner as appropriate.

The Trust has reflected carefully on the concern expressed in the Report that meaningful learning should have flowed from the circumstances of Mrs Creegan's care. We accept the need to demonstrate clearly, in coronial cases, that learning is being actively pursued and is not dependent on PSIRF alone. Our revised approach is that coronial cases of this nature will be considered through the CCRM and, where relevant, alongside other existing review methodologies so that there is explicit multidisciplinary scrutiny, clear senior clinical oversight, and a documented record of the Trust's appraisal of the care and resulting actions.

Our In-house Legal Services team hold responsibility for inquest preparation, disclosure, witness statements and legal advice, while PSIRF and other clinical governance processes contribute organisational learning and improvement insight. The CCRM serves as the formal bridge between these functions, ensuring that clinical learning, legal preparation, and coronial readiness are aligned without conflating their separate purposes.

In practical terms, the actions the Trust has taken or is taking are as follows:

- Implementation of the Coroner's Case Review Meeting (CCRM) as a formal governance mechanism for inquest and coronial case oversight.
- Requirement for multidisciplinary clinical review in relevant coronial cases, including cases where concerns arise regarding diagnosis, deterioration, monitoring, treatment, or missed opportunities.
- Senior clinical oversight through the CCRM, including the ability of the Chief Medical Officer to seek assurance, ask questions of the care delivered, and determine whether further review or organisational action is required.

- Use of multiple review routes, including MDT review, mortality review, complaints review, clinician reflections and statements, rather than reliance on PSIRF alone.
- Provision of relevant review outputs to the Coroner, where appropriate, to support transparency and demonstrate learning.
- Clarification within governance arrangements that PSIRF is one mechanism for learning, but not the sole route by which the Trust reviews deaths, identifies learning, or responds to coronial concerns.

The Trust believes this strengthened approach addresses the risk identified in your Report by ensuring that cases of this nature are now subject to broader multidisciplinary scrutiny and senior clinical appraisal, even where the matter is not progressed solely through a PSIRF learning response.

In addition to the Trust wide actions outlined above, the Geriatrics Clinical Group has reviewed the information contained within the Prevention of Future Deaths report and provides the following responses to address the specific clinical concerns raised in relation to Mrs Creegan's care.

The inaccurate cause of death initially offered by the Trust.

At the time of death certification and Medical Examiner (ME) scrutiny, there was no clinical evidence during life to suggest bacterial endocarditis. Mrs Creegan had been diagnosed with hospital acquired pneumonia and decompensated heart failure, both of which were supported by contemporaneous clinical findings, blood results, radiological imaging, and physical examination.

The diagnosis of bacterial endocarditis was only identified at postmortem examination and could not reasonably have been made during life, as the presenting features were non-specific and overlapped with alternative diagnoses that were actively treated. The responsible consultant's proposed cause of death was reviewed on two occasions by the Medical Examiner's Office and was considered appropriate based on the information available at that time.

It is well recognised that a significant proportion of causes of death are revised following postmortem examination. This does not in itself indicate a failure in care or decision making, particularly in patients who have reached the natural end of life with multiple comorbidities.

In Mrs Creegan's case, the initial cause of death reflected the best clinical judgement available at the time, rather than retrospective information gained postmortem.

The failure to investigate Mrs. Creegan's burgeoning infection after her pneumonia resolved.

Following treatment, Mrs. Creegan's pneumonia clinically improved. However, by this stage of her admission she was severely frail with significant comorbidities, and her condition had continued to deteriorate overall.

A multidisciplinary review involving the Consultant Geriatrician workforce concluded that further invasive or extensive investigations were unlikely to alter management or improve outcomes and were therefore not clinically appropriate. This decision was made in line with best interest principles and realistic treatment goals.

The treatment for bacterial endocarditis typically requires prolonged intravenous antibiotics and may involve surgical intervention. Even if an alternative infective focus had been identified at this late stage, it is highly unlikely that Mrs. Creegan would have tolerated or benefited from such treatment, and it was agreed that the most appropriate course was best supportive care.

The missed diagnosis of infective (bacterial) endocarditis.

The postmortem diagnosis of bacterial endocarditis was unexpected. During life, Mrs. Creegan did not display classical features that would have prompted suspicion, such as persistent bacteraemia, new cardiac murmurs, embolic phenomena, or a deteriorating cardiac picture unexplained by existing conditions.

While it is possible that the endocarditis developed following her surgical admission, there were no clinical indicators at the time that would reasonably have led clinicians to pursue this diagnosis. Decisions were made based on the information available and were consistent with accepted clinical practice.

The failure to monitor the development of Mrs. Creegan's heart failure during her inpatient treatment.

The alleged failure to monitor the development of Mrs Creegan's heart failure during her inpatient treatment relates to the decision not to perform a further echocardiogram (ECHO).

The decision not to repeat an echocardiogram during this admission was considered reasonable in context. Mrs Creegan had undergone an ECHO in October 2024 demonstrating preserved left ventricular function (EF 55–60%), and her subsequent clinical deterioration was attributed to fluid overload and infection, both of which were actively managed.

While hindsight raises the possibility that an ECHO might have demonstrated features suggestive of endocarditis, such an outcome remains retrospective speculation. There were no contemporaneous clinical indicators mandating repeat echocardiography, and a PSII would not reliably have identified additional learning beyond that already obtained through reflective discussion.

Mrs Creegan's heart failure was actively monitored and treated throughout her admission, including cardiology input, diuretic therapy, and adjustments to her management in response to her changing condition. Her deterioration occurred in the context of frailty, infection, and multi organ vulnerability.

Reflective learning has nevertheless taken place regarding thresholds for repeating echocardiography in complex frail patients. This learning has been shared within the Geriatrics Clinical Group to inform future decision making, while recognising that any suggestion that a different outcome would have occurred is speculative.

PSII consideration and organisational learning, reflection from the Geriatrics Clinical Group.

Following receipt of the Prevention of Future Deaths (PFD) report, further action was taken. The case was formally reviewed within the Geriatrics Clinical Group, and it was presented at Trust Grand Rounds by Dr Niranjan on 23 March 2026 and also re-presented at the Geriatrics Quality and Safety Meeting on 17 March 2026.

The group was asked to reflect specifically on whether declaring a Patient Safety Incident Investigation (PSII) would have generated additional learning beyond what had already been obtained. A full clinical timeline had already been completed; a Trust Mortality review and the case had been discussed at Trust wide meetings with senior medical representation. Reflective learning was also presented by the Quality and Safety Team to seek clinical colleagues' views on whether the incident had been managed appropriately by the Quality and Safety Advisor with a focus on ensuring optimal care and outcomes for patients going forward.

The consensus view was that:

- There was no evidence of bacterial endocarditis during life.
- Clinical decision making was appropriate and aligned with expected standards of care.
- A PSII would not have identified further learning or systemic issues.

In accordance with the Patient Safety Incident Response Framework (PSIRF), page 27, a PSII is indicated where a death is "clinically assessed as more likely than not due to problems in care." This criterion was not met in Mrs Creegan's case, and therefore a PSII was not deemed appropriate.

It is also relevant to note that, throughout the review process, Mrs Creegan's family did not wish to raise formal concerns regarding the care provided by the Trust and did not seek further engagement through the Trust's complaints or patient safety processes. The Geriatrics Quality and Safety Advisor contacted Mrs Creegan's daughter on 30 June 2025 and did not receive a response.

Meaningful family engagement is a central component of Patient Safety Incident Investigations (PSIIs), particularly where learning and improvement are the intended outcomes. In this case, in the absence of identifiable care delivery concerns and without family participation, a PSII would not have been an effective or proportionate mechanism for learning. The Trust therefore focused on thorough internal clinical review, multidisciplinary reflection, and shared learning within governance structures, all of which were completed commensurate with the information available at the time.

I hope this response provides assurance to the Court that action has been taken to strengthen the Trust's arrangements. The Trust remains committed to learning from Mrs Creegan's care and from the concerns raised during the inquest, and to ensuring that those lessons are embedded in practice through robust governance and oversight.

Yours sincerely,

[redacted]

Chief Executive
Barking, Havering and Redbridge University Hospitals NHS Trust