



**MR G IRVINE
SENIOR CORONER
EAST LONDON CORONERS COURT
QUEENS ROAD, WALTHAMSTOW, E17 8QP**

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <ol style="list-style-type: none">1. [REDACTED], Chief Executive Office, Barts Health NHS Trust2. [REDACTED] Secretary of State for Dept. Health & Social Care
1	<p>CORONER</p> <p>I am Graeme Irvine, senior coroner, for the coroner area of East London</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 24th June 2025, this court commenced an investigation into the death of John Ioannou aged 61 years. The investigation concluded at the end of the inquest on 9th March 2026.</p> <p>The inquest concluded with a Narrative conclusion, "John Ioannou died at home on 24th June 2025 having sustained a cardiac arrest brought about by peritonitis. The source of his peritonitis was an infection in his stomach and small intestine caused by a</p>

	<p>Percutaneous Endoscopic Gastrostomy (PEG) apparatus.</p> <p>Mr Ioannou's medical cause of death was determined as;</p> <p>1a Peritonitis 1b Infected Peg Tube II Congenital Cerebral Palsy</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>John Ioannou was a 61-year-old, non-verbal man who received 24-hour care in a residential care home in East London. Mr Ioannou was fed a liquid diet through a piece of apparatus called a Percutaneous Endoscopic Gastrostomy (PEG).</p> <p>On the afternoon of 23rd June 2025, Mr Ioannou attended an outpatient appointment at Whipps Cross Hospital to resolve a problem with his PEG. It was believed that the apparatus had become adhered to the lining of his stomach a process called a "buried buffer". The apparatus was manipulated, under force, to push the buffer into the void of the stomach and then to rotate the apparatus to free it from the stomach lining. In the early evening he was discharged back to his care home. No written discharge summary was provided to Mr Ioannou's carers.</p> <p>In the hours that followed, John experienced pain and became agitated. At approximately 06.45 on 24th June 2025 John sustained a cardiac arrest, despite the best efforts of the emergency services he could not be resuscitated.</p> <p>An autopsy identified that an infection, the seat of which was the PEG site, had spread from John's stomach, into his small intestine and had caused peritonitis in his abdomen.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <ol style="list-style-type: none"> 1. The Barts Health Trust chose not to investigate this case as part of NHS England's Patient Safety Framework. Mr Ioannou's death ought to have been subject to such an investigation. <p>Firstly, despite an autopsy, the aetiology and precise timing of Mr Ioannou's fatal infection was not fully understood. In a functioning clinical governance setting, both the possibility of the trust having missed a pre-existing infection at the time of the treatment on 23rd June 2025 or the prospect that the treatment itself caused the infection should have been explored.</p> <p>Secondly, in the context of the treatment of a patient with a profound learning disability where communication failures may have contributed to poor care, a valuable learning opportunity was missed.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>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.</p>
7	<p>YOUR RESPONSE</p>

	<p>You are under a duty to respond to this report within 56 days of the date of this report, namely 6th May 2026. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons the family of Mr Ioannou, the Care Quality Commission. I have also sent it to the local Director of Public Health who may find it useful or of interest.</p> <p>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.</p> <p>I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>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.</p> <p>You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.</p>
9	<p>[DATE] 10th March 2026 [SIGNED BY CORONER] Graeme Irvine</p> 