



**MR GRAEME IRVINE
HIS MAJESTY'S CORONER
EAST LONDON**

East London Coroner's Court, Queens Road Walthamstow, E17 8QP
[REDACTED]

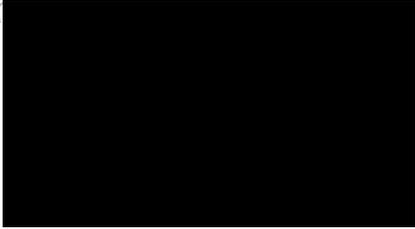
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS



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| | <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] CEO Barking, Havering and Redbridge University Hospitals NHS Trust [REDACTED]2. [REDACTED] Secretary of State for Dept. Health & Social Care [REDACTED] |
| 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.</p> <p>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p> |

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| 3 | <p>INVESTIGATION and INQUEST</p> <p>On 26th March 2025, this court commenced an investigation into the death of Sheila Creegan aged 81 years. The investigation concluded at the end of the inquest on 10th March 2026. #</p> <p>The inquest concluded with a Narrative conclusion,</p> <p><i>“Sheila Creegan died on 17th March 2025 due to infective endocarditis, a condition that was neither treated, nor diagnosed during her final, 14 day admission to hospital. Mrs Creegan's endocarditis was caused by bacteria entering her bloodstream as a consequence of abdominal surgery undertaken in February 2025. The bacteria lodged and multiplied upon calcified nodules on Mrs Creegan's mitral valve, a symptom of chronic cardiac illness. The bacterial vegetation on the valve caused haemorrhage which, in turn caused a cardiac arrest.”</i></p> <p>Sheila Creegan’s medical cause of death was determined as;</p> <p>1a Bacterial Endocarditis 1b Subacute Intestinal Obstruction (operated on) 1c Peritoneal Adhesions (previous appendicectomy and cholecystectomy) II Ischaemic and Hypertensive Heart Disease</p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>Mrs Creegan was an 81-year-old woman with extensive comorbidity including heart failure. Sheila underwent emergency abdominal surgery on 5th February 2025 for adhesiolysis. The surgery was uneventful, but Mrs Creegan’s post-surgical recovery was complicated leading to delayed discharge from hospital on 27th February 2025.</p> <p>On 3rd March 2025 Mrs Creegan was admitted to hospital by ambulance with difficulty in breathing, anaemia and a suspected GI bleed. Mrs Creegan was treated for pneumonia and fluid overload. A blood transfusion was administered. Imaging investigations found no haemorrhage or significant abdominal complication of surgery.</p> <p>By 14th March 2025 the trust determined that the chest infection had resolved, despite that, Mrs Creegan’s infection markers continued to climb, and her National Early warning Score (NEWS) deteriorated.</p> <p>Neither a septic screen nor an echocardiogram was undertaken (having previously been requested).</p> <p>Mrs Creegan died in hospital on 17th March 2025 which both the attending physician and medical examiner offering a cause of death incorporating pneumonia as the primary, direct cause of death.</p> |

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| | <p>An autopsy found no sign of extant pneumonia at the time of death and identified bacterial vegetations on the chronically calcified leaflets of the mitral valve in the heart as the primary cause of death.</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. BHRUT chose not to investigate this case as part of NHS England's Patient Safety Framework. Mrs Creegan's death ought to have been subject to such an investigation. <p>Decisions were reached at two clinical governance meetings that meaningful learning could not flow from a governance investigation into the circumstances of Mrs Creegan's care. Such decisions appear to be incongruous with;</p> <ol style="list-style-type: none"> a. The inaccurate cause of death initially offered by the Trust, b. The failure to investigate the seat of Mrs Creegan's burgeoning infection after her pneumonia resolved, c. The missed diagnosis of infective endocarditis, d. The failure to monitor the development of Mrs Creegan's heart failure during her inpatient treatment. |
| 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 by 7th 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 family of Mrs Creegan, to the Care Quality Commission, and to the local Director of Public Health who may find it useful or of interest.</p> |

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| | <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>Dated: 10/03/2026 Signed:</p>  |