REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) Chief Executive - The Whittington Hospital NHS Trust** **(2) The Partners, Northern Medical Centre, 580 Holloway Road, London**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North 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.
3	**INVESTIGATION and INQUEST** The investigation into the death of Frank POPE, aged 65, was commenced on 18 December 2013 and concluded at the end of the inquest on 2 May 2014. The conclusion of the inquest was narrative [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Mr Pope had a background medical history of ischaemic heart disease and peripheral vascular disease. His family were also concerned that he was developing dementia, although he had declined to be referred for assessment of this issue. The specific issue of whether Mr Pope had capacity to make this and other health decisions was not the focus of the inquest and was not clearly elucidated. His General Practitioners did not attend as witnesses and I decided to proceed without adjournment. Mr Pope was admitted to The Whittington Hospital several times in 2013. During the first admission in February he was diagnosed with an abdominal aortic aneurysm, although abdominal pain did not form part of his presenting complaint. His general practitioner referred Mr Pope to a vascular surgeon for investigation of his aneurysm. Mr Pope's next admission, from June to July 2013, was for abdominal pain. He was found to have ischaemic colitis, which settled with conservative treatment. He was discharged with plans for outpatient follow-up with general surgeons, vascular surgeons and cardiologists, in order to treat this condition on an elective basis. Mr Pope did not attend any of the outpatient appointments which were organised for him. His family gave evidence that Mr Pope would open letters addressed to himself (such as hospital correspondence) and not take any action. They felt that his developing dementia meant that he did not have the capacity to make this kind of decision relating to his health. As such, the family believed that they should have been informed of the dates of upcoming appointments, in order to ensure that Mr Pope attended. From the evidence

	heard at the inquest, this does not seem to have happened. It is clear that Mr Pope's general practitioner was informed when he did not attend appointments, which resulted in further referrals being made. On 6 December 2013 Mr Pope was readmitted to The Whittington Hospital with a further episode of ischaemic colitis. After an initial period during which this condition did not to warrant emergency treatment, he rapidly deteriorated on 11 December and was taken to the operating theatre. Unfortunately too much of the bowel was ischaemic for an operation to proceed. He died on 12 December.
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 will 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) Mr Pope's family had concerns, which I share, that where a patient does not have capacity to make decisions about attending follow-up consultations, appointments might be missed when family members are not copied into correspondence. It was accepted that patient confidentiality would normally preclude such direct family involvement but that there may be circumstances when it is in the patient's best interests to use this approach, to ensure follow-up occurs. It was not clear from the evidence heard at the inquest what steps are taken when a patient is deemed not to have capacity to make this type of health decision. Concerns were raised that there is no 'back-up' process in place and that future deaths could occur as a consequence.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the addressees, 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 3 July 2014. 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: (a) The Pope family, (b) The Care Quality Commission I am also under a duty to send the Chief Coroner a copy of your response. 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 by the Chief Coroner.

9	**08 May 2014** **Assistant Coroner R Brittain**