Barts Health NHS
NHS Trust

Barts Health NHS Trust
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Ms M E Hassell
Senior Coroner for Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

17 April 2015

By special delivery

Dear Ma'am,

Inquest touching the death of Mr John Dack

I write in response to your Regulation 28: Report to Prevent Future Deaths, dated 19 February 2015.

Your concern was that Mr Dack was not called for follow up because his medical notes recorded the wrong address for him, despite the fact that one of his daughters had notified staff.

Our investigation has concluded that the ward clerk was told to change Mr Dack's address by the patient's nurse. A mistake was made however as she recorded him as being of 'no fixed abode.' We have asked the ward matron to speak to her staff to remind them of the importance of accurately changing patient details and the consequences of not doing so.

This mistake did not however mean that Mr Dack was lost to follow up. On 01 August 2014, an appointment was made for 27 August 2014. Although the address on the appointment system was listed as 'no fixed abode', it is likely it was sent to his previous address. Mr Dack phoned the appointment team on 18 August 2014 to change this appointment as it clashed with another appointment. He was given a new appointment for 03 September 2014.

On 30 August 2014 he became acutely unwell and was admitted to University College Hospital on that day. There was therefore no need for him to attend his appointment at The Royal London as his condition was already being treated.

In conclusion, although a clerical error was made by a member of staff, it is clear Mr Dack did know about his follow up appointment. The importance of accurately changing patient details is being emphasized to the relevant staff.

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Thank you for bringing your concerns to my attention. I trust that you are assured I have taken them seriously and investigated them appropriately.

Yours faithfully

[redacted]

Medical Director
Barts Health NHS Trust