Regulation 28: Prevention of Future Deaths report

John DACK (died 24.09.14)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Medical Director** **Barts Health** **Royal London Hospital** **Whitechapel Road** **London E1 1BB**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 30 September 2014, I commenced an investigation into the death of John Dack, aged 58 years. The investigation concluded at the end of the inquest on 17 February 2015. I made a determination that death was the result of an accident, when Mr Dack fell at home on the morning of 8 July 2014, already compromised by a significant heart condition. I recorded a medical cause of death of: 1a bronchopneumonia 1b septicaemia 1c fractured left ankle with osteomyelitis (operated) 2 hypertrophic obstructive cardiomyopathy (HOCM)

4	**CIRCUMSTANCES OF THE DEATH** Mr Dack was admitted to the Royal London Hospital on 8 July 2014, and diagnosed first with a fracture of his right ankle, and then the following day a fracture of his left ankle. Surgeons were worried about his ability to withstand surgery because of the HOCM and so, on 17 July, he underwent a percutaneous procedure on each ankle. This was successful on the right, but not on the left, and so revision surgery was undertaken on the left on 23 July. Following a multi disciplinary team (MDT) meeting, Mr Dack was discharged home on 30 July. He was unable to weight bear. He was never seen for his planned follow up at the Royal London Hospital. I do not know whether the outcome would have been different if he had been discharged to a rehabilitation unit rather than home and/or had then been followed up as intended, but it might. The likelihood is that at some stage towards the end of August, he inadvertently put his left foot to the floor and shifted the ankle out of joint. This led to an infection. Mr Dack was admitted to the emergency unit of University College Hospital on 31 August with osteomyelitis and failure of the fixation. The metalwork was removed and an external fixator applied, but Mr Dack died on 24 September.
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 **MATTER OF CONCERN** is as follows. 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 of this on two separate occasions. What seems at first blush to be a relatively unimportant administrative matter can therefore have serious consequences. I heard from the surgeon treating Mr Dack that this has happened before with other patients. It seems that this part of the system of administration would benefit from review. (No witness was able to offer any suggestions for changes to the hospital system that might prevent inappropriate early discharge home following MDT meeting on another occasion.)

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you and your organisation 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 20 April 2015. 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted] daughter of John Dack 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 19.02.15