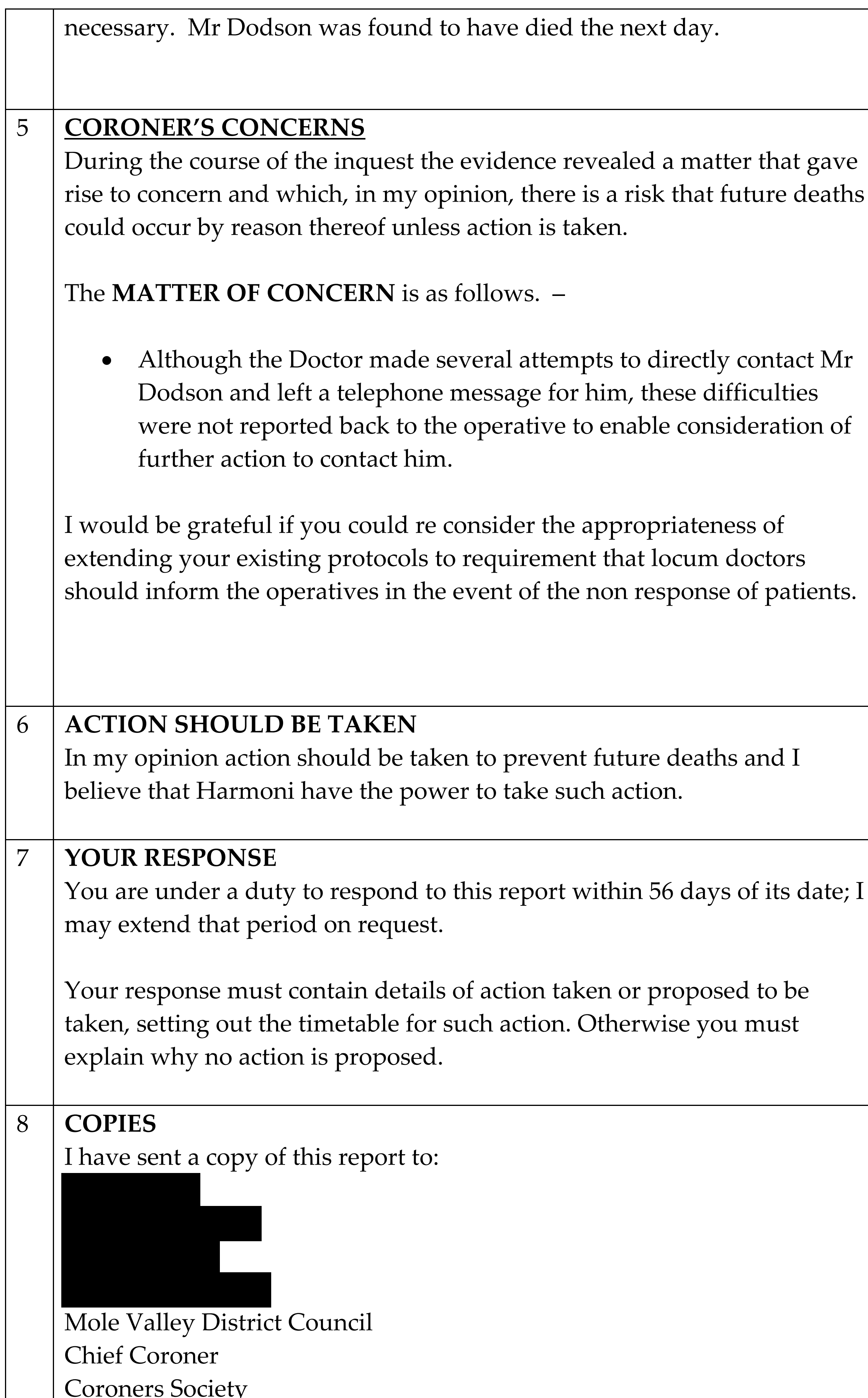
IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquests Touching the Death of Stanley Charles Dodson
A Regulation Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: Harmoni
1	**CORONER** Martin Fleming ADC Surrey
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 20 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On 9/10/12 I opened an inquest into the death of **Stanley Charles Dodson** who, at the date of his deaths was aged 84 years. The inquest was resumed and concluded on 7th November 2013. I found that the cause of death to be: - 1(a) Left Ventricular Failure 1(b) Hypertensive Heart Disease I concluded with a narrative verdict.
4	**CIRCUMSTANCES OF THE DEATH** On 1/10/12, Stanley Charles Dodson was found to have died at his home address at 2 Wallis Mews, Guildford Road, Leatherhead, Surrey. Prior to his death he had been prescribed warfarin for a thrombus and methotrexate for his Dermatomyositis, which were withdrawn by his doctor, given his failing short-term memory and confusion. Mr Dodson had a Mole Valley Community Alarm fitted and at approximately 10pm 30/9/12 he telephoned the operative to ask for a doctor to provide him with medication. The operative then contacted Harmoni to request the attendance of an on call doctor. The doctor responded by telephoning Mr Dodson 3 times but without response and he left a message on his answer phone to ask Mr Dodson to contact him or emergency services if

RT3762



	necessary. Mr Dodson was found to have died the next day.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed a matter that gave rise to concern and which, in my opinion, there is a risk that future deaths could occur by reason thereof unless action is taken. The **MATTER OF CONCERN** is as follows. – • Although the Doctor made several attempts to directly contact Mr Dodson and left a telephone message for him, these difficulties were not reported back to the operative to enable consideration of further action to contact him. I would be grateful if you could re consider the appropriateness of extending your existing protocols to requirement that locum doctors should inform the operatives in the event of the non response of patients.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that Harmoni have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to: Mole Valley District Council Chief Coroner Coroners Society

9	**DATED this 23/7/13**