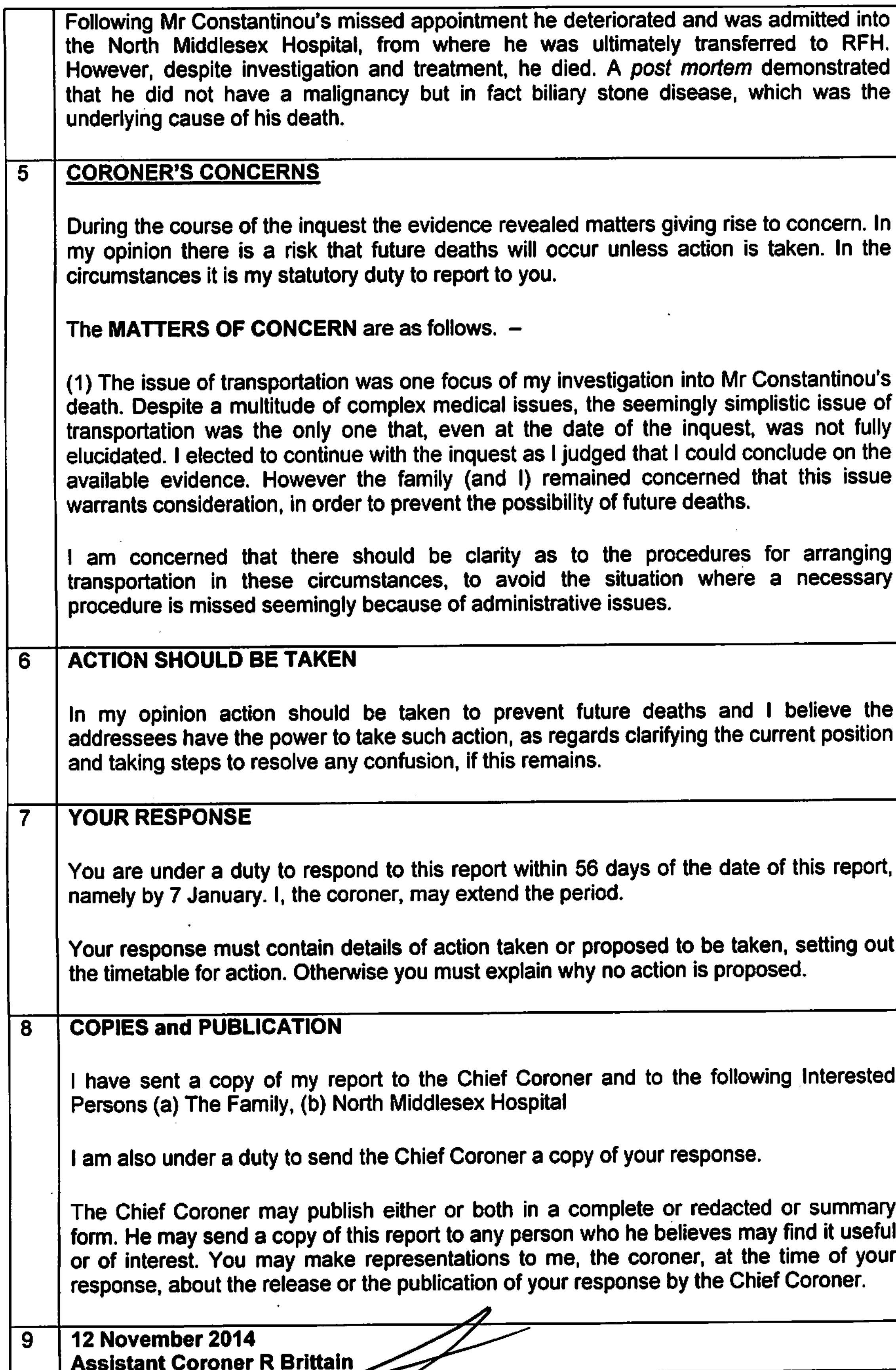
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) David Sloman, Chief Executive, Royal Free London NHS Foundation Trust** **(2) [redacted] General Practitioner, Chalfont Road Surgery, Edmonton, 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 Neophytos Constantinou concluded at the end of the inquest on 7 November 2014. The conclusion of the inquest was narrative [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Mr Constantinou died, aged 73, at the Royal Free Hospital (RFH) on 22 March 2013 from the consequences of biliary stone disease. He had been investigated for suspected malignancy at the North Middlesex Hospital through late 2012 and into early 2013. Attempts to complete the necessary procedure (ERCP) had been unsuccessful and delayed. He was referred for specialist investigation at RFH in late January 2013. Plans were made for a further ERCP to occur in early February 2013. Mr Constantinou required transportation from his home to RFH for this procedure. This had been acknowledged, as I heard evidence that a call was received querying why transport was necessary. I also heard that Mr Constantinou confirmed the need for transport with his GP who, in turn, discussed this issue with staff from the North Middlesex Hospital. Transport was confirmed as being booked through a telephone call to Mr Constantinou. However, on the day of the procedure, the planned transport did not arrive and he missed the scheduled appointment. I heard evidence, only available on the day of the inquest, that the hospital at which the procedure is to occur is usually responsible for arranging the transport. It was postulated that, where a patient has not attended the hospital before, it is for the GP to arrange transportation. This is despite the evidence presented to me from Mr Constantinou's family, who understood that North Middlesex Hospital had been central to arranging the transportation. The RFH referral form for ERCP was adduced as evidence; it includes information regarding the need for transportation as a yes/no tick box.



	Following Mr Constantinou's missed appointment he deteriorated and was admitted into the North Middlesex Hospital, from where he was ultimately transferred to RFH. However, despite investigation and treatment, he died. A *post mortem* demonstrated that he did not have a malignancy but in fact biliary stone disease, which was the underlying cause of his death.
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) The issue of transportation was one focus of my investigation into Mr Constantinou's death. Despite a multitude of complex medical issues, the seemingly simplistic issue of transportation was the only one that, even at the date of the inquest, was not fully elucidated. I elected to continue with the inquest as I judged that I could conclude on the available evidence. However the family (and I) remained concerned that this issue warrants consideration, in order to prevent the possibility of future deaths. I am concerned that there should be clarity as to the procedures for arranging transportation in these circumstances, to avoid the situation where a necessary procedure is missed seemingly because of administrative issues.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe the addressees have the power to take such action, as regards clarifying the current position and taking steps to resolve any confusion, if this remains.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 7 January. 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 Interested Persons (a) The Family, (b) North Middlesex Hospital 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	**12 November 2014** **Assistant Coroner R Brittain**

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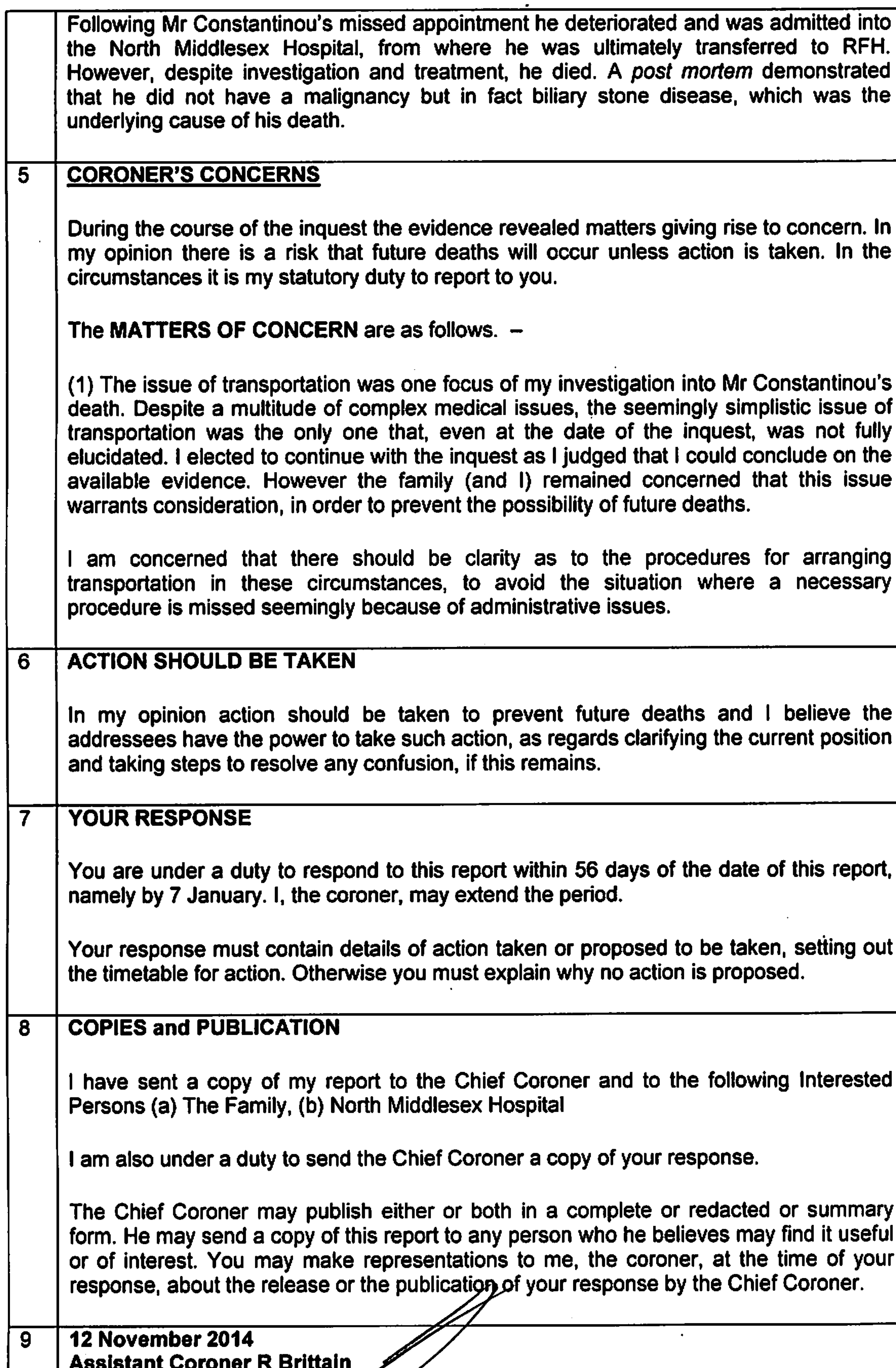

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