Regulation 28: Prevention of Future Deaths report

Bronwyn Ann WILLIAMS (died 23.05.17)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Principal Dentist** **Kindandental** **99 Newington Green Road** **Mildmay Ward** **London N1 4QY** **2. [redacted]** **Medical Director** **Homerton University Hospital NHS Trust** **Homerton Row** **London E9 6SR**
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 25 May 2017 I commenced an investigation into the death of Bronwyn Williams, aged 68 years. The investigation concluded at the end of the inquest on 4 September 2017. I made a determination as follows. Bronwyn Williams died on 23 May 2017 from a retropharyngeal abscess. This is a naturally occurring, albeit rare condition. She had consulted at an accident and emergency unit on 1 May 2017 and been referred to a dentist.

	She saw her dentist on 4 May 2017 and was referred to a maxillofacial unit. She was due to be seen within two weeks, but the dental surgery system of referral was postal rather than electronic and then the hospital did not provide an appointment within two weeks, so she was not seen again before her death. Her medical cause of death was: 1a septicaemia/mediastinitis 1b retropharyngeal abscess 1c gum infection 2 type II diabetes mellitus
4	**CIRCUMSTANCES OF THE DEATH** Ms Williams saw a dentist at Kindandental on 4 May 2017, having attended the emergency unit of Homerton University Hospital on 1 May and been told to visit her dentist, complaining of pain preventing mouth opening other than to a very limited extent, and a general malaise. Neither intra oral examination nor imaging was possible at the dental surgery, because of the extent of the trismus. The dentist therefore prescribed a five day course of antibiotics and referred Ms Williams to the maxillofacial unit of the Homerton on an urgent basis. The word urgent in this context means that an appointment should be fixed to take place within two weeks. On 10 May, Ms Williams rang the dental surgery to say that she had seen on her copy of the referral that her road name had been misspelled and her postcode had been omitted. This was rectified and a further referral sent to the Homerton. Ms Williams died before ever receiving her appointment.
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. Some matters have already been dealt with following Ms Williams' death. However, **MATTERS OF CONCERN** remain as follows. 1. I heard at inquest that the urgent referral from Kindandental to the Homerton was made not by logging on to a portal, or by email, or by fax, but by post. This seems unduly slow, cumbersome and prone to mishap.

	2. Following Ms Williams' attendance at the dental surgery on 4 May, an appointment with the maxillofacial unit was made for 30 May, then cancelled by the Homerton on 23 May and re-fixed for 19 June. This date is nearly seven weeks post referral.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 13 November 2017. 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 Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted], son of Bronwyn Williams 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** 13.09.17