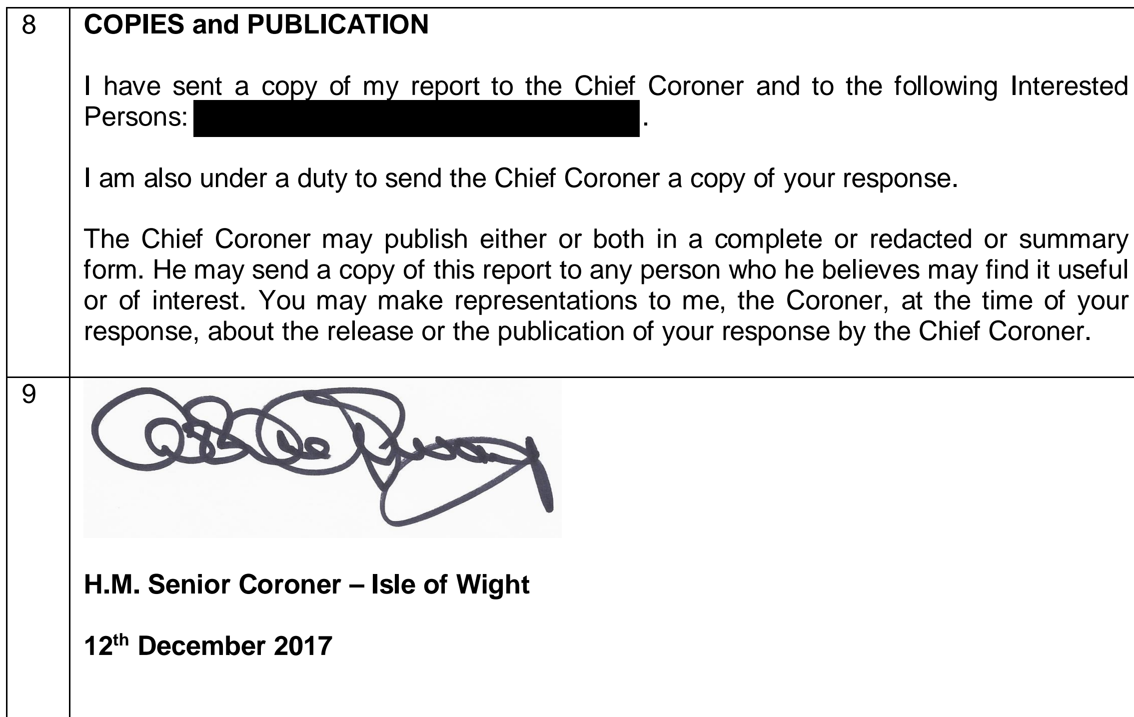
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. Ms Maggie Oldham, Chief Executive, Isle of Wight NHS Trust** **2. Executive Director of Clinical Governance at St Mary's Hospital, Newport, Isle of Wight** **3. Care Quality Commission**
1	**CORONER** I am Caroline Sarah Sumeray, Senior Coroner for the Coroner Area of the Isle of Wight.
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** On 17th July 2015 I commenced an investigation into the death of Joseph Peter Dunne, aged 58. The investigation concluded at the end of the inquest on 12th July 2017. The conclusion of the inquest was a short narrative conclusion as follows: "Joseph Peter DUNNE initially presented at his GP's surgery on 14th July 2015 complaining of pain around his ribs. The examining GP consulted a senior colleague and they requested a 999 ambulance fearing that this was Cardiac related. Upon arrival at St Marys Hospital, a junior doctor took a history and examined the patient before requesting various tests and investigations. The abnormally high d-dimer result was phoned back to the A&E department and although there is evidence that this was added to the patient's electronic notes before being deleted again, due to Information Governance breaches, it cannot be said that the junior doctor saw this abnormal result before discharging the patient back to his home address with analgesia and antibiotics. The deceased subsequently saw his GP the next day and was examined and plans were made for the District Nurse to visit him. He was found collapsed at home by the District Nurse the next day and died shortly thereafter."

	The medical cause of death was found to be: 1a Peritionitis 1b Perforated Duodenal Ulcer 1c II
4	**CIRCUMSTANCES OF THE DEATH** 1) Joseph Peter Dunne was born on 17th January 1957. At the time of his death he was 58 years old and worked as a chef. 2) Mr Dunne was a relatively heavy drinker, drinking approximately 10 cans of lager a day and smoking approximately 20 cigarettes a day. He had been diagnosed with diabetes and had hypertension which was controlled with medication. He had recently lost a lot of weight. 3) On Tuesday 14th July, Mr Dunne visited his GP complaining of pain down one side and generally feeling unwell. As the GP feared that the pain might be cardiac related, an ambulance was requested, which took him to the A&E Department of St Mary's Hospital, Newport, Isle of Wight, arriving at approximately 6 p.m. Mr Dunne then had various routine tests and investigations carried out during the 4 hours that he was at St Mary's Hospital. These included tests for D-dimer and a chest x-ray which were ordered by the FY2 doctor who examined Mr Dunne. The D-dimer results were authorised in the laboratory at 20.27 hours and phoned through to another Emergency Department doctor at approximately 20.30 hours. This result was entered into the clinical record under the FY2 year doctor's login at 20.30 hours (but the person who entered the information is unidentifiable). There was a further entry with regard to the chest x-ray results. Both the entries for the D-dimer and the chest x-ray were deleted simultaneously on Mr Dunne's notes. The FY2 doctor then re-entered the information at 21.38 hours in Mr Dunne's records about the chest x-ray alone. The D-dimer result was not re-transcribed. It was believed that the FY2 may have deleted the earlier results as they had been entered under another user's login. Regrettably, no consideration and weight was later given to the D-dimer result. 4) Mr Dunne was subsequently discharged at approximately 10 p.m. that evening with a diagnosis of suspected pleurisy. 5) The following day, Mr Dunne attended his GP's surgery and complained that he still felt unwell. His GP arranged for him to be visited at home by the Community

	Matron on Thursday 16th July. 6) On Thursday 16th July, Mr Dunne got up but still felt unwell so he soon returned to bed. His partner went out at 10 a.m. At approximately 2 p.m. the Community Matron attended his house and he was found by her to be collapsed by conscious on the living room floor. He was very cold with a temperature of 34.2C. His partner was summonsed and she returned home. At around 2.15 p.m. Mr Dunne indicated that he wished to use the toilet. He was supported by his partner to reach the toilet. Whilst on the toilet he suddenly became unresponsive and collapsed to the floor. An ambulance was immediately summonsed and CPR was undertaken by the Community Matron. When the paramedics attended, they took over the CPR, however there were no signs of life and he was pronounced dead at 3.20 p.m.
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. I am concerned that there are clear breaches in Information Governance protocols. It is clear that there are IG issues which allow one Clinician to make entries or delete information from a patient's medical records, when they are not correctly logged in to the database, or are doing so under a colleague's log-in (which remains live after they've walked away from the computer terminal). Matters are compounded inasmuch as these edits are then found to be invisible to those clinicians who are actually treating the patient, and are only ascertainable when an IT audit trail is undertaken. It should not be possible for Doctor A to be able to access records made by Doctor B and to alter those medical records.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 12th February 2018. 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: [redacted]. 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	**H.M. Senior Coroner – Isle of Wight** **12th December 2017**