# **REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)**

NOTE: This form is to be used after an inquest.

## **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

#### THIS REPORT IS BEING SENT TO:

- 1. The Royal Bolton Hospital NHS Foundation Trust
- 2. C/o Mark Reynolds Solicitors
- 3. Chief Coroner

### 1 | CORONER

I am Simon David Allen Jones H M Assistant Coroner, for the Coroner Area of Manchester West

## 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 29<sup>th</sup> July 2014 I commenced an investigation into the death of Patricia Edge, 66. The investigation concluded at the end of the inquest on 3<sup>rd</sup> December 2014. The conclusion of the inquest was that the cause of death was:-1a)Ischaemic bowel

- 1b) Bowel obstruction
- 1c) Advanced colorectal carcinoma
- II) Paracetamol liver toxicity

The conclusion was that Patricia Edge was diagnosed with diverticulitis following admission to the Royal Bolton Hospital on the 10th May 2014 with a history of abdominal pain and diarrhoea since February 2014. A colonoscopy was planned but she was readmitted on the 14th July 2014 when she was prescribed an excessive dose of paracetamol which was not corrected until the 19th July 2014. A biopsy taken on the 28th June 2014 had resulted in a report dated 2nd July 2014 confirming the presence of bowel cancer. A CT scan on the 16th July 2014 showed the cancer had spread and the bowel was obstructed. The obstruction led to the bowel becoming ischaemic - a rare condition - and her condition deteriorated and she died at the Royal Bolton Hospital on the 20th July 2014.

## 4 CIRCUMSTANCES OF THE DEATH

Patricia Edge died in Royal Bolton Hospital of bowel cancer, but an excessive dose of paracetamol dispensed between  $14^{th}$  and  $19^{th}$  July 2014 contributed to her 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 circumstances including training of staff and Trust procedures in which a patient could be prescribed and dispensed an excessive dose of paracetamol on the 14<sup>th</sup> July 2014.
- (2) The apparent lack of any review of the paracetamol dose between 14<sup>th</sup> and 19<sup>th</sup> July 2014.
- (3) The apparent failure to carry out blood tests between 14<sup>th</sup> and 19<sup>th</sup> July, which would have revealed/confirmed the possibility of the dose of paracetamol being excessive, again considering issues of training and procedures.

#### 6 ACTION SHOULD BE TAKEN

In my opinion urgent action should be taken to prevent future deaths and I believe 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 7<sup>th</sup> February 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 Chief Coroner and to the following Interested Persons

(daughter of Patrica Edge).

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	Dated	Signed
	10/12/2014	Simon David Allen Jones