

Mark Andrew Beresford Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Ms Louise Barnett, Chief Executive,
1	Rotherham Hospital NHS Foundation Trust Moorgate Road Rotherham S60 2UD
	I am Mark Andrew Beresford, Assistant Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On 27/05/2015 I commenced an investigation into the death of Hayley Christine Clark, 36. The investigation concluded at the end of the inquest on 12 April 2016. The conclusion of the inquest was a Narrative conclusion as follows: Hayley Christine Clark died, at Rotherham Hospital, on 24th May 2015, from the effects of severe malnutrition. Her malnutrition arose from a combination of factors, which did not include anorexia, but which did include poor eating discipline due, in part, to longstanding abdominal discomfort. The cause of death was 1a. Respiratory failure, 1b Pulmonary oedema, 1c Severe multi-factorial malnutrition, 2. Acute pyelonephritis, electrolyte imbalance, anaemia and immune deficiency
4	CIRCUMSTANCES OF THE DEATH
	 Hayley Christine Clark was a 36 years old female with a medical background which included long term malnutrition, hypogammaglobulinemia, irritable bowel syndrome, anaemia and depression.
	She was admitted to Rotherham General Hospital on 12 th May 2015 with electrolyte imbalance.
	3. As part of a standard package of pain management, Ms Clark received Paracetamol. However the dose administered was the standard adult one and had not been adjusted to reflect Ms Clark's extremely low (less than 50kg) body weight. This overdose of Paracetamol caused derangement of Ms Clark's liver function. The problem was identified, the Paracetamol was withdrawn and Parvolex was administered.
	 Ms Clark's condition deteriorated. She was transferred to the High Dependency Unit on 22nd May 2015 and she died on 24th May 2015. The cause of her death was as set out above.
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) There was a failure, on the part of the staff who prescribed and administered the Paracetamol to Ms Clark, to recognise the need to adjust the dosage (in evidence the required reduction was said to be 50%) to reflect Ms Clark's extremely low body weight.
6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe you Ms Louise Barnett, Chief Executive, 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 Tuesday 7th June 2016 . 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:
	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 12 April 2016
	Signature