	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Medway NHS Foundation Trust**
1	**CORONER** I am Patricia Harding Senior Coroner for **Mid Kent and Medway**
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 17/03/2017 I commenced an investigation into the death of Claire Joan Elizabeth MEDHURST. The investigation concluded at the end of the inquest. The conclusion of the inquest was an open conclusion with how when and where the deceased came by their death being recorded as: Claire Medhurst died from the consequences of fulminant liver failure caused by a polypharmacy overdose on 24th February 2017 at King's College Hospital liver unit where she had been transferred after presenting to Medway Maritime Hospital on 27th January 2017. That she had acute liver failure on admission as a result of the ingestion of an unknown quantity of paracetamol was not recognised or treated for some six hours by which time her condition had significantly deteriorated. Claire Medhurst had previously been admitted to Medway Maritime Hospital on 22nd January 2017 following a polypharmacy overdose which was treated and resulted in a discharge as medically fit on 25th January 2017. Although in taking the first overdose she intended to end her life, her intention in ingesting further paracetamol cannot be determined from the evidence.
4	**CIRCUMSTANCES OF THE DEATH** On 22nd January 2017 Claire Medhurst aged 37 was admitted to Medway Maritime Hospital having taken a poly pharmacy overdose the significant components of which were paracetamol and ibuprofen. She was provided with n-acetyl cysteine infusions in accordance with national guidance and was discharged on 25th January 2017 when medically fit, blood tests at the conclusion of treatment showing normal liver function. She underwent a mental health assessment prior to discharge which established that her intention in taking the medication was to end her life and whilst she still had suicidal thoughts she had no plans to end her life. As a result of this and the fact that she was prepared to engage with the mental health team in the community, she returned home. On 27th January 2017 she was readmitted to Medway Maritime Hospital with abdominal pains. She denied having taken further medications. A blood sample taken shortly after her admission revealed grossly abnormal liver function and a toxic level of paracetamol. The clinicians were not alerted to the results by the laboratory, nor did a clinician review the results when reported. As a result there was a delay in treatment with n-acetyl cysteine of some six hours by which time her condition had significantly deteriorated. She was admitted to the Intensive Treatment Unit for stabilisation before being transferred to King's College Hospital Liver Unit on 28th January 2017 where despite supportive measures being provided she further deteriorated and died on 24th February 2017. The medical cause of death was established to be: 1a Multi Organ Failure b Fulminant Liver Failure c Polypharmacy Overdose II Hepatic Steatosis
5	**<u>CORONER'S CONCERNS</u>** 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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The discharge process on 25th January 2017 did not include any cautionary advice as to the further

	use of medications such as paracetamol or ibuprofen as an analgesic particularly when Claire Medhurst had been experiencing headaches shortly before discharge and had been prescribed ibuprofen (2) The treating clinicians did not receive an alert from the haematology laboratory for the abnormal results for ALT and toxic levels of paracetamol
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Medway NHS Foundation Trust 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 9th October 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 Chief Coroner and to the following Interested Persons Next of Kin, Kent & Medway NHS and Social Care Partnership Trust. I have also sent it to Care Quality Commission who may find it useful or of interest. 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	10/08/2017 Signature:  Patricia Harding Senior Coroner **Mid Kent and Medway**