ANNEX A

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. Medical Director, [redacted], Mid Yorkshire Hospitals NHS Trust, Aberford Road, Wakefield, WF1 4DG**
1	**CORONER** I am David Hinchliff, Senior Coroner, for the Coroner Area of West Yorkshire (Eastern).
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 the 27th September 2016 I commenced an Investigation into the death of Jennifer Ann Midgley, aged 65. The Investigation concluded at the end of the Inquest on 26th September 2017. The conclusion of the Inquest was in narrative form, a copy of which is attached hereto, including the medical cause of death of:- 1(a) Multi-organ Failure associated with Acute On Chronic Liver Failure 1(b) Paracetamol Toxicity on a background of Non-alcoholic Fatty Liver Disease with Cirrhosis 1(c) Fracture of the Left Femur (Operated 24/09/2016) 2 Malnutrition associated with Severe Chronic Obstructive Pulmonary Disease
4	**CIRCUMSTANCES OF THE DEATH** Jennifer Ann Midgley suffered with chronic obstructive pulmonary disease which had caused her to become malnourished and underweight. This caused her to have non-alcoholic fatty liver disease with cirrhosis. On 22nd September 2016 she fell at her home, fracturing her left neck of femur which was surgically repaired at Pinderfields Hospital, Wakefield on 24th September 2016. Post-operatively she was prescribed paracetamol for pain relief. This was administered both orally and intravenously. When administered intravenously the dosage should be adjusted to compensate for the patient's weight. Mrs Midgley was given at least one dose of paracetamol intravenously which was not calculated according to weight and was therefore an overdose, causing her to develop organ failure as a contributory factor in 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) I was informed that the drug administration chart does not clearly distinguish between the administration of oral and intravenous paracetamol, nor does it have any reference to a patient's weight in respect of intravenous administration. (2) I recommend that the Trust's drug administration chart should be redesigned and include separate columns indicating oral and intravenous administration of paracetamol. (3) When paracetamol is administered intravenously there should be a reference on the chart to the patient's weight, and also a reference as a reminder that intravenous dosage of paracetamol should be modified according to the patient's weight.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 30th 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 Chief Coroner and to the following Interested Persons, [redacted] Messrs Wosskow Brown Solicitors, 31 Regent Street, Barnsley, S70 2HU. 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	**5th October 2017**  **DAVID HINCHLIFF** **Senior Coroner** **West Yorkshire (Eastern)**