Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 TPP LTD**
1	**CORONER** I am SARAH HUNTBACH ASSISTANT CORONER for the coroner area of Derby & Derbyshire
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 05 January 2022 I commenced an investigation into the death of Jade Paula REVELL aged 30. The investigation concluded at the end of the inquest on 22 March 2023. The conclusion of the inquest was that: Jade Revell was taken to Chesterfield Royal Hospital on 25 December 2021 having suffered a sudden cardiac event at home. Despite extensive resuscitation she passed away in hospital the same day. Jade suffered with an eating disorder and was under the care of the mental health team. Prior to making a change to her medication her bloods were tested. On 27 October 2021 the bloods were electronically sent to Jade's GP practice. These showed a low potassium level which required further action. There was a failure to notify Jade of this result. This caused a missed opportunity to medically treat the hypokalaemia and monitor the potassium levels which increased the risk of ventricular fibrillation and sudden cardiac death.
4	**CIRCUMSTANCES OF THE DEATH** Jade Revell died from a sudden cardiac event. A missed opportunity to treat hypokalaemia shown in blood results on 27 October 2021 has more than minimally contributed to the cause of the sudden cardiac event.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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) The SystemOne computer programme used by the GP Practice can, when a clinician is reviewing the results (blood) from the laboratory with the screen in minimised mode (which is not unusual because of a need to work with a split screen), not show all the results. To do so would need the clinician to scroll down and a scroll feature is not available. This gives rise

	to the risk of an abnormal result being missed and unactioned. Abnormal (out of range) should be more visable – appear at the top of a list and colour coded to minimise the risk of a result not being seen / missed. The computer programme prevents this.
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 May 17, 2023. 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 have also sent it to [redacted] (Miss Jade Revell's mother) [redacted] (Miss Jade Revell's father) [redacted] – Primary Health Care who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 23 March 2023** Sarah Huntbach **Assistant Coroner** **Derby & Derbyshire**