Kate Robertson
Assistant Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Health Board (BCUHB)
1	**CORONER** I am Kate Robertson, Assistant Coroner for North Wales (East and Central)
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 11 January 2023 an investigation was commenced into the death of Eric Thompson (DOB 13/4/1941) who died on 28 December 2022. The investigation concluded at the end of the inquest on 14 June 2024. The narrative conclusion of the Inquest was as follows:- Eric Thompson died on 28 December 2022 at Ysbyty Glan Clwyd where there were missed opportunities to provide timely care and treatment to prevent the condition, hyperkalaemia, which contributed to his death at this time.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Eric Thompson presented at Ysbyty Glan Clwyd on 27 December 2022 at 13:58 with confusion and poor mobility on the background of treatment for a urinary tract infection. He had bloods taken at 17:28. An attempt was made by the laboratory to telephone the emergency department with the abnormal results (high potassium). There was no answer. A second attempt was made at 18:35 and the results were relayed to the department. These were not initially documented or escalated but had been included on the system. Eric Thompson remained in the department. At 21:35 a clinician noted a high NEWS score (7) and became aware of the abnormal blood results. Eric Thompson did not receive treatment for the hyperkalaemia. He went into cardiac arrest at 02:50 and died shortly thereafter. He died from cardiac related issues contributed to by hyperkalaemia and diabetes mellitus.

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 – The abnormal blood results were telephoned through to the emergency department as required by the current system within an hour of the blood being taken to highlight the abnormal results. The results were available on the system; but they were not initially documented by the emergency department following the telephone call. They were not actioned, nor were they noted until many hours later until a clinician actively considered the electronic emergency department medical records for Mr Thompson. There is no electronic or IT method or system by which the laboratory can send the results to the emergency department quickly and efficiently with an alert to indicate abnormal results. Instead, the system relies on person-to-person discussions and for this to then be escalated, as necessary.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 9 August 2024. I, Kate Robertson, 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 Family of the Deceased and to the Chief Coroner. 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 14 June 2024

	 Signature Assistant Coroner for North Wales (East and Central)