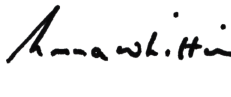
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 [redacted] CEO Bedford Hospitals NHS Foundation Trust**
1	**CORONER** I am Emma WHITTING, Senior Coroner for the coroner area of Bedfordshire and Luton Coroner Service
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 26 September 2023 I commenced an investigation into the death of Jacqueline GREEN aged 72. The investigation concluded at the end of the Inquest on 01 April 2025. The **Narrative Conclusion** of the Inquest was: ***The Deceased suffered from acute on chronic kidney impairment and kidney infection but died from paracetamol induced liver failure whilst being treated in hospital***
4	**CIRCUMSTANCES OF THE DEATH** *At around lunchtime on 29 August 2023, the Deceased was admitted by ambulance to Bedford Hospital, having been found on her bedroom floor. She had reported to her carer that she had been there since falling in her dining room and crawling to her bedroom two days previously. She was described by the attending paramedics as being very weak, very slim and frail. In the Accident and Emergency Department, it was noted she was cachectic and dehydrated but her liver function tests were normal. She was admitted to a ward later that evening. Her weight was not taken prior to nursing staff asking a night junior doctor (who had not seen her nor had access to her records) at around 23.37 hours, to prescribe her with paracetamol. As the doctor was unaware that she weighed less than 50 kg, she was prescribed 1,000 mg of paracetamol to be taken 4 times daily. Although nursing staff estimated her weight at 44 kg the following day, and her actual weight was confirmed to be 33.6kg sometime on 31 August 2023, she continued to receive the prescribed dose of paracetamol until the evening of 31 August 2023, when the last dose was withheld by nursing staff. The reason for the withholding of the last dose of paracetamol on 31 August 2023 remained unclear. At around 11.20 hours on 1 September 2023, she suffered an episode of coffee ground vomiting. She continued to receive a further dose of paracetamol at 11.48 hours on 1 September 2023 but at the lower level of 500 mg. The reason for the reduced dose was also not clear. Following receipt of blood test results at 13:28 hours on 1 September 2023, which showed a significant derangement in her liver function, the administration of paracetamol ceased, and she was treated for paracetamol induced liver injury. Despite treatment, her condition deteriorated and as she was not a candidate for a liver transplant or intensive care treatment, she was placed on end-of-life care. She passed away at the hospital on 3 September 2023; her death being confirmed at 22.12 hours. Post-mortem examination confirmed that, whilst her fall and initial admission were due to acute on chronic kidney impairment and kidney infection, her immediate cause of death*

	was liver failure.
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) 1. Despite the fact that the HSSIB made *Safety Observations* to mitigate the risks of unintentional paracetamol overdose in adult inpatients with low bodyweight in their National Report dated 24.02.2022 (https://www.hssib.org.uk/patient-safety-investigations/unintentional-overdse-of-paracetamol-in-adults-with-low-bodyweight/) none of these had been addressed/adopted at Bedford Hospital by the time of the Deceased's admission on 29 August 2023 which meant that, despite weighing only 33.6kg, the Deceased was prescribed a daily dose of 1,000 mg x 4 which was only suitable for a patient weighing in excess of 50kg. 2. A lengthy PSII investigation (completed on 16 September 2024 and received by the Senior Coroner on 24 October 2024) delayed the hearing of the Inquest but also left unanswered questions. In particular, there was no explanation as to why the nursing staff, having estimated the Deceased's weight at 44 kg the day after the paracetamol was prescribed (which although quite incorrect was still below the threshold for a prescription of that level) still proceeded to administer the prescribed dose yet did not administer the last dose on the night of 31 August 2023 and administered only ½ the prescribed dose the following morning. Further exploration of this with the relevant staff might well highlight additional safety concerns (for example, did nursing staff feel unable to challenge the prescription directly with the doctors?). 3. Despite the PSII report referencing the 2022 HSSIB report and recommending that this should be shared with staff, relevant *Safety Observations* made in the HSSIB Report appear to have been insufficiently addressed: (a) Although Bedford Hospitals NHS Trust are now using the Nervecentre electronic record system which, since 28th February 2024, has included the height and weight of patients and prevents a prescribing doctor from prescribing without a patient's weight having first been entered, staff are still able to enter a estimated weight and there do not appear to be any alerts on this system to advise of the need for weight accuracy in the prescription of oral paracetamol and consideration of the risk of liver toxicity in those weighing under 50 kg (as advised in *Safety Observation* 02/2022/151); (b) Whilst the PSII report states as an Action that "*Patients should be weighed on admission and the information documented*", other than the provision of a 'pat slide', no other practical actions are planned for actually achieving this outcome, particularly in respect of those adults at risk of an unintentional paracetamol overdose, such as an alert aimed at those administering medication as well as those prescribing it (as advised in *Safety Observation* 02/2022/151).
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 30, 2025. 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] 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: 04/04/2025**  **Emma WHITTING** **Senior Coroner for** **Bedfordshire and Luton Coroner Service**