MS N J MUNDY
H M CORONER
SOUTH YORKSHIRE (East District)

[redacted]

CORONER'S COURT AND OFFICE
CROWN COURT
COLLEGE ROAD
DONCASTER DN1 3HS

[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive, Rotherham District General Hospital

1. CORONER

I am Louise Slater, Arear Coroner for South Yorkshire East District

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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3. INVESTIGATION and INQUEST

On 24 December 2025 I commenced an investigation into the death of Barbara Joan COPE. The investigation concluded at the end of the inquest .

The conclusion of the inquest was Accident.

The cause of death was:

1a Multi-organ failure

1b Acute Liver Failure

1c Inadvertent Paracetamol Toxicity

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4. CIRCUMSTANCES OF THE DEATH

This case relates to the death of a 75 year old woman who presented to Rotherham Hospital on the 11th June 2025 with decreased conscious levels, slurred speech and reduced oral intake. A stroke was ruled out and blood tests performed at 16:06 hours on the 12th June 2025, were undertaken to consider a unintentional staggered Paracetamol overdose. These tests were reported at 17:11 hours and confirmed a high level of paracetamol.

Despite clinical deterioration and two medical reviews overnight, these blood tests were not reviewed or acted upon until 10:00 hours on the 13th June 2025, delaying the administration of N-Acetylcysteine (NAC) until 12:30 hours, approximately 19 hours later after the results were available. Paracetamol excess requires time critical management to prevent further and irreversible damage to the liver.

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) Although a blood sample was collected and tested in a timely manner, there was no evidence of communication and/or follow up of the abnormal result, therefore time critical medication was not commenced until 19 hours later.

(2) Even when the patient clinically deteriorated overnight and required two separate clinical reviews, the blood results were not reviewed and/or acted upon. If clinical records and recent investigations results are not reviewed then appropriate medical management will be delayed or will not occur.

(3) This patient was transferred from the emergency department to the care of Surgery. A referral was then made for Gastroenterology input, they then requested a blood test for paracetamol levels. This was not followed up for 17 hours. There needs to be clear communication, understanding and record keeping of who is responsible for patient and the ongoing follow up and care in these circumstances.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you Dr Jenkins 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 **Wednesday 5th August 2026**. 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] Secretary of State for Health & Social Care.

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.

8 June 2026

Signature

Louise Slater Area Coroner for South Yorkshire East