John Adrian Gittins
Senior Coroner for North Wales (East and Central)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
1	**CORONER** I am John Adrian Gittins, Senior 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 the1st of December 2020 I commenced an investigation into the death of Rhian Margaret Roberts (DOB 6.8.70 DOD 25.11.20) The investigation concluded at the end of the inquest on the 13th of July 2021. The conclusion of the inquest was one of misadventure with the cause of death being 1(a) Multi Organ Failure (b) Paracetamol Toxicty
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Mrs Roberts's death are that she was admitted to Glan Clwyd Hospital on the morning of the 22nd of November 2020 after being found unresponsive at home as a result of a presumed overdose. Tests undertaken on admission to hospital established that she had extremely high levels of paracetamol in her system and although these results were available on the portal at 11.57, the treating clinicians in ICU did not become aware of this until the early hours of the following morning, when action was then taken by the administration of N-Acetylcysteine. Despite this treatment she continued to decline and passed away on the 25th of November 2020.
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. On arrival at ICU the clerking-in doctor requested a toxicology screen to include paracetamol and salicylate levels (notwithstanding that blood tests to include this were already in hand) and there was no evidence available at the inquest to establish whether or not the toxicology screen requested by the doctor was undertaken and if not why not. 2. An internal investigation by the health board following Mrs Roberts' death rightly established that action needed to be taken to update or modify the SOP for communicating of life-threatening blood results directly with clinical areas and an action plan indicated that this would be completed by the 30th of June 2021. At the time of the inquest on the 13th of July, the proposed update remained in draft form only and had not yet been approved. 3. I am concerned that the continual delays in investigating adverse incidents, sharing learning and implementing actions following the same, create risks to patient safety.

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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 by 8th of September 2021 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 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 14th July 2021 Signature  Senior Coroner for North Wales (East and Central)

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