	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Heart of England NHS Foundation Trust**
1	**CORONER** I am Emma Brown Area Coroner for **Birmingham and Solihull**
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 30/12/2016 I commenced an investigation into the death of Ahsiyah Bibi. The investigation concluded at the end of an inquest on 27th April 2017. The conclusion of the inquest was Natural causes.
4	**CIRCUMSTANCES OF THE DEATH** The Deceased passed away in Birmingham Heartlands Hospital during the afternoon of the 22nd December 2016. She had been admitted shortly after midnight with reduced consciousness. It was evident in the early hours of the morning that she was suffering acute renal failure. She did not respond to treatment and was not a suitable candidate for dialysis and was declared deceased at 16:10. During the course of her treatment she was given an overdose of insulin – this is unlikely to have contributed to her death. There was also a delay in the commencement of treatment for high potassium but this is also unlikely to have contributed to Mrs. Bibi's death. Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: 1a Acute Kidney Injury of unknown origin. 2 Congestive cardiac failure, ischaemic heart disease, obstructive sleep apnoea, diabetes
5	**<u>CORONER'S CONCERNS</u>** 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. When reviewing Mrs. Bibi at 02:14 [redacted] did not have the results from an arterial blood gas performed by the nursing team at 01:52 which demonstrated high potassium therefore treatment for high potassium was not commenced until approximately 04:00 when the high potassium had been identified. It was the evidence of [redacted] and [redacted] that from time to time the hard copy blood gas results do get separated from the records and if the Clinician doesn't know the test has been undertaken they will have no reason to go and source the results. 2. At 04:00 a drug error was made in the prescribing and dispensing of Actrapid insulin for hyperkalaemia: Mrs. Bibi was prescribed a 50 unit dose instead of a 10 unit dose, the error was identified when she had received 20 units and the infusion was stopped. The evidence of [redacted] who prescribed the insulin was she knew the Trust's protocol and standard treatment to be a dose of 10 units but made a mistake. It appears from investigations carried out by [redacted] that the two members of the nursing staff who dispensed the dose did not check the dose. Professor Hanif, Consultant in Diabetes, gave independent expert evidence that in his view there

	is a risk of inappropriate prescribing of insulin in the management of hyperkalaemia because clinicians are more commonly called upon to prescribed a 50 unit does for Hyperglycaemia. Therefore in his opinion a system is required to avoid error in cases of hyperkalaemia. [redacted] agreed that the fact she more commonly prescribes a 50 unit does of insulin for hyperglycaemia probably did explain her error. 3. [redacted] evidence was that although he has investigated the insulin prescribing error and it has been discussed with the individuals involved there has not been a Trust wide review of the risks of this occurring again and consideration of a system to reduce the risk of error. The problem of missing blood gas results was identified by [redacted] but not considered for further action within the department or across the Trust.
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 27th June 2017. 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: the family of Mrs. Bibi. 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	30/04/2017 Signature Emma Brown Area Coroner **Birmingham and Solihull**