University Hospitals Birmingham NHS
NHS Foundation Trust

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Ref: JMLTR/BROWN 0802 2016/NS

8 February 2016

Ms Emma Brown
Area Coroner
Coroner's Court
50 Newton Street
Birmingham
B4 6NE

Dear Madam

Joyce Beatrice Tozer (deceased)

In response to the Report to Prevent Further Deaths issued by you on 15 December 2015, following the inquest in to the death of the above, I am writing to inform you that this Trust has taken action as follows:

A round table meeting was held on 24th December to discuss whether an overdose was a causative factor in the death of the deceased. The roundtable review noted that the deceased had become unwell following administration of 100ml Visipaque (Omnipaque was incorrectly documented in the medical notes, the correct contrast agent is recorded on the Trust's imaging system. 100mls is considered to be a standard dose; Visipaque is iso-osmolar and therefore theoretically less toxic than Omnipaque).

The Trust's protocols regarding the administration of intravenous contrast agents were considered, together with the manufacturer's guidelines for administering Visipaque and available literature relating to similar use. The review found that:

1. The radiographer administering the contrast acted entirely appropriately and within the limitations of the expanded practice IV protocol;

2. The contrast dose administered to the deceased was not outside of the manufacturer's range or that of the literature for this technique; and

3. When carrying out interventions with contrast media, there are occasions when the recommended dose (per unit body weight) is exceeded. However, this is not undertaken without an assessment against the risk of not obtaining adequate images of the relevant body part and the inherent risk to the patient in not completing the intervention.

The review concluded that there was not an overdose and that it is probable that the deceased died of a rare allergic reaction to the Visipaque, and not from the toxicity of the agent.

I trust the action taken will provide you with assurance that doses of contrast in excess of manufacturer's guidelines are not frequently administered in this Trust and that, therefore, patients are not exposed to risks from toxicity.

If you require any further information please do not hesitate to contact:

[redacted], Director of Corporate Affairs
0121 371 4317
[redacted]

Yours sincerely

Dame Julie Moore
Chief Executive