REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Ms Jackie Bene, Chief Executive, The Royal Bolton Hospital, Minerva Road, Bolton. BL4 7HR 2. Mr Roy Blay, Chief Executive, WellSky, 1 Aurum Court, Sylvan Way, Southfield Business Park, Basildon, Essex, SS15 6TH 3. Mr Andy Thorburn, Chief Executive, EMIS, Aspinall House, Aspinall Close, Middlebrook, Horwich, BL6 6QQ
1	**CORONER** I am Rachel Syed, HM Assistant Coroner for the Coroner Area of Manchester West.
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 the 09 August 2019, I commenced an Investigation into the death of Irene Whittingham, born on the 24th November 1932. The Investigation concluded at the end of the Inquest on the 21 February 2019. The medical cause of death was: - 1a) Bilateral Hypostatic Pneumonia 1b) Multi Organ Failure 1c) Hypercalcaemia due to Vitamin D Toxicity II) Hyperparathyroidism, Ischaemic Heart Disease and Nephrosclerosis The Inquest conclusion was Accident contributed to by Neglect.
4	**CIRCUMSTANCES OF THE DEATH** The deceased died at The Royal Bolton Hospital on the 31st July 2019 from the toxic effects of a Vitamin D overdose. The deceased suffered from a number of medical illnesses, including liver and kidney disease, hyperparathyroidism with Vitamin D malabsorption, small vessel

	disease and hypertension for which she was receiving treatment for these conditions. On or around the 22nd March 2019, the deceased was admitted to hospital with seizures and it was clinically suspected that the cause was due to a cerebral event. Investigations also revealed low Vitamin D levels and advice was sought from a Specialist who recommended 20,000 international units of Vitamin D to be given twice a week for 3 months. In error, the discharge summary incorrectly recorded the Vitamin D to be given once a week. The ward pharmacist picked up the error but incorrectly amended the discharge summary for the medication to be given twice daily. No advice was given about monitoring the deceased's blood levels whilst she was being loaded on a high dose of Vitamin D which exceeded the national guidelines. The deceased was deemed fit for discharge on the 12th April 2019 and her prescription was dispensed in the community. On the 10th June 2019, the deceased was readmitted back to hospital and treated for acute kidney injury and Vitamin D toxicity. The deceased's condition did not improve and she died on the above date.
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: During the Inquest, evidence was heard that: - 1. Conflicting guidance is provided to treating clinicians as to when Vitamin D and Calcium blood level monitoring should be undertaken especially in patients who are given higher (loading) doses of Vitamin D, which exceeds the recommended national guidelines. The Consultant in Acute Adult Medicine gave evidence that he expected blood level monitoring to have taken place within 4 weeks of the loaded Vitamin D commencing, whereas the Endocrinologist, gave evidence that he expected blood level monitoring to take place around the 3 month period to ensure the course of medication had been completed. In any event, no advice or instructions were issued to the deceased GP, regarding any requirement to monitor the deceased blood levels whilst she was in the community and taking high levels of Vitamin D which exceeded national guidelines. 2. I request that The Chief Executive of The Royal Bolton Hospital reviews: i. The guidance and practices being adopted by staff, in regard to when blood monitoring of the above types of patients should take place to ensure a consistent and safe approach is adopted.

	3. The WellSky and EMIS Software, had a confusing user drop down menu option, which allowed the user to click on a twice daily dose despite the loaded dosage, exceeding national guidelines. 4. I request that The Chief Executives of WellSky and EMIS Software company reviews: 5. The dropdown user options to ensure better system safety nets are put in place to prevent catastrophic prescribing errors occurring in the future
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 **24TH April 2020**. 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:- 1. [redacted] Son of deceased 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** **28th February 2020**
	Signed Rachel Rahella Syed **Rachel Syed** **HM Assistant Coroner**